State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 1:42 P M APR. 10, 2005 NETTIE I HARVEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4 SERPEN COURT **ESSEX** BALTIMORE tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR. 8, 1944 6 Sax 7 Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ F Yrs. MARYLAND 60 218-42 7761 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28e-f show traumatic event, the Medical Examiner must be notified at ☐Yes 2☐No Director MD. BALTIMORE **ESSEX** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4 SERPEN COURT 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Voivorced permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural" any injury or other traumatic event, Ite Mudical Expone. "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ONE YEAR HUMAN SERVICE WORKER CITY OF BALTIMORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CARL JEFFERSON ETHEL COKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4904 CRENSHAW AVE, APT B PALTO MD 21206

ce of Disposition (Name of Date 20c. Location - City or Town, State KIMBERLEY HARVEY (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY APR 15,2005 BALTIMORE, MD. * 4 ☐ Donation 5 ☐ Other (Specify) Ignature of Funeral Service License CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Dulmonare Priysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 No the 9 Unknown 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not regulting in the underlying cause given ja Part I. Records, Mromic. 1 Yes 2 No 3 Probably 4 Unknown Completed - Alcoholism rterosclerofic Cardiovascular discose 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has anemic Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SX Residence 6 Other (Specify) P 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 ☐ Pending 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerat L Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier D-17992 4-12-05. and Towson and 2/286 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHIN-M. TIJN 1312 Goucher 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item/5, 10f, 18,19b, per FH, G842, 4719/05 IT

			1 - For State Registrar	State of Ma		artment of Health and rtificate of Death	Mental Hygien	2007 12307
	Physici /Medic		1. Decedent's Name (First, Middle, Las	KESS			4	Day Year 3. Time of Death 22005 830 m M
	Examir	ier	4a. Facility Name (If not institution, give FUTURE CARE 5. Social Security Number 6. So	OLD COYR	T N (+	4b. City, Town, or Location of Dea RAW A AUS TO If Under 1 Year If Under 24 Hi	WN	IC. County of Death BALTIMORE O Rightplace (State or Foreign
	Funeral Director			X M 2□ F	81 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign 23 MARYLAND
	e-f show	ctor	10a. State 10b. County 10b. A		10c. City, Town or Lo	ocation BALTIMORE CITY	Ĭ	10d. Inside City Limits Y es 2 □ No
	ath with th	Funeral Director	10e. Street and Number 3921 BELLE AVE			10f. Zip Code 21207 2		Citizen of What Country?
9036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23e or 28e-f show event, Lie Medical Exara net must be inclified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2544 If Yes, Give Year or Dates:	lo lo	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2 ☐ XNo Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
1215	d within 72 h giene. er than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10TH	lucation de completed) College (1-4or 5	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired) LIFT OPERATOR	rorking	Kind of Business/Industry P WAREHOUSE
land	5 g g 7	To Be C	17. Father's Name (First, Middle, Last) RODRICK ALEXA			PAULI		Y
	1 and 2 Health a am 27 Is		19a. Informant's Name/Relationship (7 LINDA LEE AVEF 20a. Method of Disposition		SHTER 39	21 BELLE AVENU	UE, BALTIM	or Town, State, Zip Code) 21215 IORE, MD 21207 Location - City or Town, State
	permit. Pages Department of h Importent: If ite any injury or of once.		1 Surial 2 □ Cremation 3 □ 1 □ Cremation 3 □ 1 □ Cremation 3 □ Cremation 3 □ 21. Signature Funeral Service Licen	")	KING ME			ANDALLSTOWN, MD WERAL HOME 21207
6	9 5 6 8		23a. Partr. Enter the disease, or comphock, or heart failure. List only	plications that caused one cause on each lir	UUVV	600 LIBERTY HO ter the mode of dying, such as cardi		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	ARDION	4SCVD		Onset and Death
8760, Ø	cate be executed bhysician and the burial-transif	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		-,			
	he death certifi the attending p thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		23d. Date of delivery Month Day Year			
rds, P	w requires fhat ti been signed by should be detac	ed by Pt	Part II. Other significant conditions c	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Hunknown			
II Reco	The law afe has b page 2 s	Completed by		24a. Was an autopsy performed?				
Vita	Physician: Th this certificafe ral direcfor, pag	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only one)	
o	<u> </u>	n: To	1 Yes 2 PNo 27. Manner of Death	1 ☐ Inpatie	ry 28b. Time o	at 28c. Injury at	Home 5 Residence	
<u>-</u>	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		ury - At home, farm, st	Work? M 1 □ Yes 2 □ No reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Aural Route Number, ate)
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	G Tarking To	W	29b. Signature and title of certifier	· Nen	مَا الله	29c. License number D 373	33 AF	and place, and due to the cause(s) Date signed (Month, Day, Year) PRIL 12, 2005
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print) Print) PL TO. MO	21133	
	Sta	ate	31. Date filed (Month, Day, Year)	105 32 legistra	ar's Signatur	DEAL!		

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan		artment of I rtificate of		and M		giene Reg. No.	005	12504
П	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	Eva Stella Larm 4a. Facility Name (If not institution, give si			4b. City, Town, o	or Location o		April	11	2005 ounty of Death	
	Examin	er	Union Memorial			Baltim		or Death		40.0	N/A	'
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da 0 1 / 2 1	th V Year)		place (State or Foreign
	Director		212-01-9101	M 2 M F 85	Yrs.	IVIOITIIS Days	110013	IVIIII.	01721	/1920	Mar	yland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Mary a-f sh	tor	Maryland N/A	Bal	timor	е						1 XYes 2 ☐ No
	or 284	Funeral Directo	10e. Street and Number			10f. Zip Code				10g. Citize	n of What Co	untry?
	ath w	ral	1101 N. Calvert			21202					ed Sta	
	itams Itams	nne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of I If Yes, specify Cub	Hispanic Ori an, Mexican	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.)	- 14	Race - Amer Black, White	
20	urs af	by	3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□Yes 2No	Specify:			s	pecify: Whi	te
215-0036	shouid be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or itams 23a or 28a-f show marked other than "natural" or itams 23a or 28a-f show maric event, the Medical Exacting that the routhed at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occu kind of work done	during mos	t of worki	na	16b. Kind	of Business/I	
121	within ne. ihan "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	od)			M	. .	
2			17. Father's Name (First, Middle, Last)		Asse	шрту	18. Mothe	er's Name	(First, Middle		ufactu umame)	iring
au	should be nd Mental markad o	To Be	Peter Paul Lesni	iewski					Czast			
Maryland 21	2 shou and M is mar aumat	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street						ip Code)
	of Heelth of Heelth litem 27		Wanda Nagrabski			s. Milt		-				
Baltimore,			20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re			sition (Name of matory or other pla		04/1	5/05		ation - City or	
<u>=</u>	permit. Pag Department Importent: I eny injury o		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicease			sary Ce 2. Name and Addre				Balt:	imore,	Maryland
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	Physician		Immediate Cause (Final disease or condition	Serri	(2							9 hpure
	/Medical Examiner		resulting in death)	Due to (or is a consec	uence of):							
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× 6	death certific e attending p id for use as t	Physician/Me	IF FEMALE:	Bc. If yes, outcome of pregna	ancv					22	d. Date of deli	von
Box	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\overline{\text{No}} \)	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnand Other (specify)	:y			25	Month	Day Year
o.	by the	hys	9 □ Unknown	9□ Unknown								
Ś	The law requires that the de tte has been signed by the a bage 2 should be detached f	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I	•		tobacco use Yes 2 🗷		the cause of death?
000	e law re has bev ge 2 sho	piet							24a. Was		24b. Were au	topsy findings available ompletion of cause of
<u> </u>		Completed								ormed? 2 No	death? 1 ☐ Yes	2 No
Vital Record	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		0			(Check only			
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Division of	or Attandii after death. Diractor: A in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	reet, factory, office			28f. Location (City or To		Number or Ru	ral Route Number,
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1	MI		30. Name and address of person who con	mpleted cause of death (Item 20 i	п 23a) (Турв. EAS+ l	Print) Iniversity	Park	way	Bal	Himo.	re, r	005 10 21218
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature				-	· · · · · · · · · · · · · · · · · · ·			

Dillott 17 Flev 1/2001

		-	For State Registrar	State of Ma	aryland /	-	rtment of He		nd Menta		ne 2 0	05	1250	5
	0.		1. Decedent's Name (First, Middle, Las	t)				1	2. Dat	e of Death	Day	Year	3. Time of Death	
	Physicia /Medic		Barbara	М.	Мо	orse				pril		0.5	7:05 p. ^M	
}	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or I	Location of D	Death		4c. County	of Death		
		v	11000 Marty Stre	et			LaVale				A1	1egar		
	Funeral		Social Security Number 6. Security Number	9X 7. Ag	e (In yrs. last b		If Under 1 Year Months Days		Min. (Mo	e of Birth nth, Day, Y	ear)	9. Birthp	lace (State or Foreign try)	
	Director		236-68-2589		60	Yrs.			Feb	. 19,	1945	Keys	er, WV	_
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					1	0d. Inside City Limits	_
	f sho	ō	WV Mine	1		7							1∑Yes 2☐No	
	the 288-	Director	WV Mine:	Lal		Keys	10f. Zip Code			100	J. Citizen of V	What Cour	ntry?	
	3a or	0	40 Sharpless St	reet			267	26			USA	1		
	ter death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		n? (Specify Ye	s or No-	14. Rac	e - Americ		
Maryland 21215-0036	a p E	by Fur	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates:	No		Yes, specify Cubar		Puerto Rican,	9(C.)	Specify		eic.	
Š	72 hours natural,	Completed	15. Decedent's Ed		16	a. Deced	lent's Usual Occupa kind of work done d	tion	of working	16	b. Kind of B			
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pu	should be filled within 72 ho nd Mental Hygiene. marked other than "natur matic event, 'ne Medical	Be (17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First,	Middle, Ma	aiden Suman	ne)		
<u>yla</u>	should be and Mental las marked o	မ	Bernard W. Min						ginia					_
lar	2 shd and is m		19a. Informant's Name/Relationship (g Address (Street a				City or Town,	State, Zip	Code)	
	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Ronald W. Morse/	Husband			East Wing sition (Name of	nebago	Stree Date		oenix, Oc. Location			_
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	Removal from State	ceme	tery, cren	natory or other place		April	8	oc. Location	Oily of 10	JWII, Otato	
Ë	permit. Pages Department of Important: If it any injury or c		* 4 □ Donation 5 □ Other (Specif	y)	The C		rland Cre				Cumbe		d, MD	_
39	permit Depar Impor any in		21. Signature of Funeral Service Licer	3° 8 -	7/	22	. Name and Addres		DMITCH		ral Ho			
	403.00		23a. Part1. Enter the disease, or com	Journal that muse	the death D	o not ent	85 S. Mai		·			2672	Approximate	-
			shock, or heart failure. List only	one cause on each li	ne.								Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. NON			CELL CF	702010	NOMH	OF	LUN	(-	DC+ 2002	2
	Examiner			Due to (or as	a consequenc	e of):								
8		50	Sequentially list conditions,	b. Use to (or se	a consequence	tel of):								_
	ted nsit	n in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequenc	e of):								
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9	ificate g phy as the	edic		•										
Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)				1	ate of deliver	ery Day Year	
P.0	that the	Ph	Part II. Other significant conditions	contributing to death t	out not resulting	g in the u	nderlying cause give	n in Part I.	23	Be. Did toba	acco use con	tribute to t	he cause of death?	
ds,	signe d be	d by								1 Yes	2 □ No	3 🗆 Prot	babiy 4 Dunknown	
Vital Records,	w requir been s	Completed							24	a. Was an	24b.	Were auto	posv findings available	,
360	has has	ld m							_	autopsy perform	ed?	death?	opsy findings available impletion of cause of	
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ξ	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital:	ent 2 ER/	Outpation	nt 3 DOA Othe		sing Home 5				0	1,700
of	두 두 교	- T	27. Manner of Death	28a. Date of Inj (Month, Da		outpatier b. Time o					v injury occur		.,,	
on	ding f h. After funer	tion	1 Natural 5 Pending investigation		ay Year)	Injury		(? Yes 2.∐N	0					
Division	Attending r death. sctor: After by the fune	Certification;	3 Suicide 6 Could not b	e 28e. Place of In	jury - At home,	, farm, sti	reet, factory, office		28f. Lo	cation (Str	eet and Num	ber or Run	al Route Number,	
Ö	after after Dire	erti	4 Homicide	building, e	tc. (Specify)				Ci	ty or Town,	State)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)	nysician: To the best miner: On the basis and manners	of examination	dge, deat and/or in	h occurred at the tim vestigation, in my of	ne, date and pinion, death	place, and du n occurred at t	e to the car he time, da	use(s) and m te and place,	anner as s , and due t	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	100	7/		29c. License	number		29	d. Date signe		and the same of th	
		1		11	1		D 06	233	71		APRI	117	,2005	
	1	I	30. Name and address of person who	completed cause of	death (Item 23	a) (Type		-						
1	0		Qamar Zaman, M		Kent Av			cland.	MD 2	1502				
	St	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	9								_
	Regist		APR 1 3 200	5	K	book	les							
DI		2001	HAK 1 9 500	- Julian	70		ne t							

ORIGINAL

			State of Maryland / Depa 1- State of Maryland / Depa 1- Registrar	rtment of Health and M ificate of Death	lental Hygie	ene 0 0 5	12506
П		爱	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Bernice Lillian Rosel	oro McDaniel	Month 3	Day Year 2005	12:45 p. M
	/Medic Examin			4b. City, Town, or Location of Death		4c. County of Dea	
25	Examini	ر. م	319 E. 21 1/2 Street	Balto		N/A	
	Funeral		5. Social Security Number Unk 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	g Bir	thplace (State or Foreign
	Director		214-26-2044 1□ M 2X F 82 Yrs.	Months Days Hours Min.	(Month, Day, Y	1922	S.C.
		Ì	Usual Residence of Decedent		10 20	1) 6 6	
	how		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
	Ma S-t-s	cto	Md N/A Balto				1 XYes 2 No
	th the	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	ountry?
	th wil		319 E. 21 1/2 Street	21218		USA	
	dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W Armed Forces? 15.	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
٥	or Ite	3	1 Never Married 2 Married 1 Yes 2 No		rican, etc.)	Black, Whit	
3	d within 72 hours after death with the Maryland jene. Ir then "naturel", or Items 23a or 28e-f show It a Medical Exar. it wit matter multifud at	d by	3X Widowed 4 □ Divorced Year or Dates:	☐ Yes 2¼☐ No Specify:		Specify: B1	ack
9500-512	72 h natu	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation and of work done during most of work	ina 16	b. Kind of Business	/Industry
7	ithin	du	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)	-	Private H	omes
7	filed within I Hygiene. other then "rent, I'm Me.	Co		estic Worker			
Maryland	m - 0 %	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	niden Sumame)	
<u>X</u>		2	George Roseboro	Lucy Wil	lliams		
<u>a</u>	d 2 should th and Mer 7 ie marke treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rura	al Route Number, (City or Town, State, .	Zip Code)
	and ealth n 27 ner tr		Miracle Barnes - Granddaughter 319	E. 21 1/2 Street	Balto.	Md 21218	
9	tges 1 and nt of Health if item 2; or other t		20a Method of Disposition 20b, Place of Disposi	ition (Name of atory or other place)	Date 20	c. Location - City or	Town, State
Ĕ	Pages ment of ant: If its ary or o		'4 Donation 5 Other (Specify) Arbutus M	emorial Pk 4/5/	['] 2005 A	rbutus,Md	
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Fundial Service Licensee 22.	Name and Address of Facility Ma	rch F/H	West	
n	88 = 8		Mrette K. mes	4300 Wabash	Avenue B	alto, Md	21215
			23a. Part1. Enter the Isease, or complications that the used the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac	or respiratory arres	t,	Approximate
- 2	Physician		Immediate Cause (Final	11. 5.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	maruten			-
	Examiner		Dia has a consequence on.				
		e	Sequentially list conditions if any, leading to immediate b.				
	nsit	Examin	cause. Enter Underlying Cause (Disease or injury	15-1120x 12-	373		
	al-tra	xa	that initiated events resulting in death) Last C. Due to (or as a consequence of):	la rives	20030		
09/8	icate be executed physician and s the burial-transit	dlcai	1 type ten Co	1117			
200	icat ph s th	pe	0.				
×	death certific e attending p id for use as l	Z/M	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	in and
gox	atter for u	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
o.	0 0 0	ysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Gillor (Gpoony)			
7	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds	sign d be	d by		ficiency	1 ☐ Yes	2 □ No 3 □ Pi	obably 4 Honknown
ecords,	w requires that been signed b should be deta	Completed					
ě	9 4 9	Id II			24a. Was an autopsy performe	24b. Were at prior to death?	utopsy findings available completion of cause of
	ilcian: The l certificate ha rector, page				1 Yes 2		2 No
Vital	or Attending Physician: ifter death. Director: After this certifici	Be	25. Was case referred to medical examiper? Hospital:		(Check only one)		
0	Phys this al dir	은	1 Inpatient 2 EN/Outpatient				cify)
	ding F h. After funera	on:	27. Manner of Death 1 Statural 5 □ Pending 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	Work?	28d. Describe how	injury occurred	
DIVISION	uttendi death. ctor: A y the fu	Certification	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
≥	or At fter c jirec in by	Ħ	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or R. State)	ural Route Number.
	urs a						
	Hosp 4 hor Fune ely fi	ical	29a. Certifier (Check only (Ch	occurred at the time, date and place, astigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fu	Medical	one) and manner stated.				
	To To	~	29b. Signature and title of certifier	29c. License number D 31Y & Y		I. Date signed (Mont	
•			10 With	221769	4	3/30/0	7
1	(30. Name and address of person who completed cause of death (Item 23a) (Type, P	Print)			
1			SHOAII3 A HASHMI 821 N		Inde I	US , 150	
	Sta		31. Date filed (Month, Day, Year) APR 1 3 2005	1. 1.			WD FIEOL
	Registr	ar	MENTO ZUUD P Allegaro As	MONEY			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** John N. Martin 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7.4 Yrs. Months Days Hours Min. Oct. 27, 1930 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 M 2 □ F 215-28-2774 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "naturel", or items 23a or 28e-f show or other treumatic event, the Modical Exx. invert. ust be notified at 1 ☐ Yes 2 ☐ No Directo Bel Air Md. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1615 Ruger Drive 21015 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 ☐XNo Specify: Specify: ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years tool and dye maker can industry permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event, size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) August Martin Paulina Popp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Ruger Drive, Bel Air, MD 21015 Cynthia L. Holder/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 4/12/2005 Baltimore, Md. 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee a 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sd 26 hours CI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 20 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 X No CC. To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA this 28b. Time of Injury in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

A 31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29b. Signature and title of certifier

THEMPSON Bloom ! Sperter

29c. License number

D0053568

500 upper Chasapinks

, Maryland

29d. Date signed (Month, Day, Year)

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Fundar United Value Flags Social Security Number 214 - 0.2 - 20.26 1.0 m. 26 F. 2.2 Vrs. Months Days Hours Months Days	imore place (State or Foreign ryland 10d. Inside City Limits 1 □ Yes 2 □ No ntry? can Indian, etc. ite dustry o Code) own, State
Usual Recidence of Denocedent Too Survey That State Too Survey The	10d. Inside City Limits 1 □ Yes 2 □ No ntry? can Indian, etc. i.te dustry c Code)
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Physician Medical Examiner Physician Medical Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 23b. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 23c. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 23b. Due to (or as a consequence of): 2ac. Due to (or as a co	TID
Physician Medical Examiner Ph	
Due to (or as a consequence of): Consider the constraint of the	Approximate Interval Between Onset and Death UNKNOWN
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Proleman	
	ery Day Year
	**
25. Was case referred to medical examiner? 1	opsy findings available mpletion of cause of
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	
C 2 3 5 O 1 X Natural 5 Pending (Montin, Day Year) Injury Work?	у)
27. Manner of Death 1 Natural 2 Death of the control of the co	al Pouto Alimbar
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a contribution one of the contribution of the contribution of the cause of	ar moute reamber,
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, 4/9/20	stated.

DHMH 17 Rev 1/2001

APR 1 3 2005 Sessee & Speller

		1 - For State Registrar	State of Ma	•	partment Certificate			l Mental H	lygien Reg. N	2111	15	12509
Physic		1. Decedent's Name (First, Middle, Las. John W. Narer,					1	2. Date of Month	Death Da		Year 205	3. Time of Death 6:20 A M
/Medi Examir		4a. Facility Name (If not institution, give	SPITAL		BAL	TIM		MARYLA	AND 4	c. County		
Funeral Director		5. Social Security Number 6. Se 219–26–8437 1] Usual Residence of Decedent		(In yrs. last birthd	Months		If Under 24 H Hours M	s. Date of l (Month, Feb.	Birth Day, Year 12,	939	Cour	place (State or Foreign otry) y Land
Maryland s-f show	tor	10a. State 10b. County Maryland Baltimon	re	10c. City, Town of Arbuti							1	0d. Inside City Limits
th with the 23s or 28	Funeral Director	10e. Street and Number 5640 Carville A	ive.		10f. Zip 0						zen of What Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Interpreted to Heatth and Mental Hygiene Important: If item 27 is marked other than "netural, or Itams 23a or 28a-f show any injury or other treumatic event, Ita Madical Experit at martice and lifed at once.	by Funer	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent Yes, specification 1 Yes 22	ly Cuban,	anic Origin? Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-		k, White,	ean Indian, etc. hite
d within 72 ho giene. or than "netui	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 10		-) (G	ecedent's Usual live kind of work e. DO NOT use chinist	done dui	on ing most of w	vorking		Kind of Bu		dustry
12 should be filed within in and Mental Hygiene. 7 Is marked other than "reumatic event, Ite Market	To Be C	17. Father's Name (First, Middle, Last) John Narer, Sr.	 			1		ame (First, Midda a Geckl		n Sumam	ө)	
and 2 sho fealth and m 27 Is m her treum		19a. Informant's Name/Relationship (T) Pamela Narer, w	, , ,	56	640 Carv	ville		Arbutus	, MD.	21	227	
permit. Pages 1 ar Department of Hea mportent: If item any injury or othe anses.		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,		BayView	7°Cremat	or place) OTY		15-05	Bal	timo		
permii Depar Impor any ir		21. Signature of Funeral Service Licens			1328 S	ulph	ur Spr	Home, Ing Rd.	Arb	utus	, MD.	21227
Physician /Medical Examiner but and physician and physician and the prijal-transit the prijal-transit	dicai Examiner	23a. Fart1. Enter the disease, or some shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	CIR NCEPF	RH	05/5	ž	Onset and I I YEM I YEM			Approximate Interval Between Onset and Death JERR JERR JERR		
ath certifi ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic pred					23d. Date Mon		ry Day Year
w requires that the de been signed by the a should be detached	by	Part II. Dther significant conditions co					e cause of death? ably 4 Unknown					
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Physicien: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 🔀 Inpatien	t 2 ER/Outpa	tient 3 DOA	Othor		eath <i>(Check onl</i>) Home 5□Re		6 □Othe	r (Specify	r)
tending leath. tor: After the fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day 28e. Place of Injur building, etc.	Year) Injur y - At home, farm,	M		s 2 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Ro			l Route Number,	
To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/or	eath occurred at r investigation, in	the time, n my opin	date and pla- ion, death oc	ce, and due to the	e cause(s e, date an) and mar d place, a	nner as stand	ated. the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier Nodora A	Viculesco	~ , MD		License n	umber 05					2005
01		30. Name and address of person who or TEODORA NICULESCU A	ompleted cause of dea	ath (Item 23a) (Type ES HOSP 17	pe, Print) AL, 900 (ATON	1 AVEKR	IE, BALT.	MORE	E, M.	ARYL	AND, 21229
Sta		31. Date filed (Month, Day, Year)	32. Registr		March							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year John Bernard Naditch 7, April 2005 2:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2425 Lakewood Road Parkville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 18, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1110 M 2 □ F 79 212-20-3198 Yrs. 1925 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or items 23e or 28e-f show other treumetic event, the Medical Examitian must be a validied at 1 ☐ Yes 2 🙀 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2425 Lakewood Road 21234 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. h Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Charles Naditch permit. Pages 1 and 2 should I Department of Health and Men' Importent: If item 27 Is marke Irene Ironside 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Biro 2425 Lakewood Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State any injury once. ↑ Donation 5 ☐ Other (Specify) Dulaney Valley 4/11/05 Baltimore, Maryland of Furreral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road baltimore, maryland 21206 Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm e Ca se (Final disease or con on resulting in death) ARCINOMATOSIS **Physician** /Medical CARCINOMA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Physicien: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE IF FEMALE:
23b. Was decedent problem in the past 12 months?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERS 1 Yes 2 No 3 Probably 4 Unknown Completed been DUSLIPIDEMIA 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred NA Hospitel or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation NA ofter death Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) NA 4 Homicide within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3805 WOIZRIS VILCE RD JAR JARRETTSUILLE 31. Date filed (Month, Day, Year) 32. Registrar Signature Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	Stete Unpend Item		me G8	342 _{Ce} 7	illicate or	Seath		Reate of Deat		2005	3. Time of Death
Physician /Medical		1. Decedent's Name (First, Middle, Karen There	sa Poffley					AP	lonth	06,	2005	2:30a M
Examiner		a. Facility Name (If not institution, UPPER CHESAPEAK)				4b. City, Town, or BEL AIR	Location of De	eath			ounty of Death FORD	
Funeral Director		5. Social Security Number 214-78-6554		ge (In yrs. las 48	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. Fe	ate of Birth donth, Day, D. 16	Year) 9	9. Birthi Cour 57 Mart	place (State or Foreigr ntry) YLAND
Mo to	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
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ms 23a or 28a-1 show result be notified at neral Director		10e. Street and Number 6511 Upland R	oad			10f. Zip Code	1051		"	-	en of What Cou	ntry ?
at, or its	200	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces	? (No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? In, Mexican, Pu Specify:	(Specify) lerto Rican	(es or No- i, etc.)		Race - Amen Black, White, Specify:	
"natur		15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of t f)	working		16b. Kind	d of Business/In	ndustry
giene.	5	Elementary/Secondary (0-12) 12th Grade	College (1-4or	5+)	Care	egiver					ralthca	re
ital Hygind other avant, I	ב	17. Father's Name (First, Middle, L Lawrence	^{ast)} Newell				18. Mother's M			Maiden Si LLNC		
and Mental I Is marked of raumatic ava	2 -	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street						c Code)
alth an 27 Is 27 Is ar trau		Trevor Poffley				Upland		ork,		21051		
rage net o int: If iry or		20a. Method of Disposition 1			aney	esition (Name of matory or other place Valley Me	m'l 4/		05	Timo		aryland
Departmen Important: any injury once.		21. Signature of Funeral Service L	icensee Ville			2. Name and Addre 105 Belai						S
*		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause	ed the death. line.								Approximate Interval Between Onset and Death
Appropriate transit as the burial-transit as	Evalilli	disease or condition resulting in death) Sequentially list conditions. Lacing to include yield cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a conseque s a conseque	nce of):	rosclerot						
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cate has been sign page 2 should to	naiduio							-	24a. Was a autops perfori	sv l	24b. Were aut prior to co death? 1 X Yes	opsy findings available on pletion of cause of 2 No
certificate harector, page	D	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place of		9,5000111			
fing Phys		1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending investig	28a. Date of In (Month, D		R/Outpatie 28b. Time o Injury	of 28c. Inju	4 Nursir		5∐ Reside Describe ho		Other (Speciocourred	rfy)
To the Hospital or Attends within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Medical Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 200. Flace UII	Injury - At hon etc. (Specify)		reet, factory, office			ocation (Si City or Town		Number or Rui	ral Route Number,
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	dicai C	29a. Certifier 1 Certifyin (Check only one)	g Physicien: To the bes Examiner: On the basis and manner	of examination	rledge, dear on and/or in	th occurred at the tinvestigation, in my	me, date and popinion, death of	lace, and o occurred at	due to the c the time, d	ause(s) a late and p	and manner as place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	1	1		29c. Licens	se number		2	29d. Date	signed (Month	, Day, Year)
,		30. Name and address of person	who completed cause of	f death (Item :	23a) (Type	OCME	1		I	APRII	06, 20	005
5		S.D. H	0(91 AT	-		111 Pe	nn Stre	et Ba	altimo	ore,	Maryla	nd 21201
State Registra	-	31. Date filed (Month, Day, Year)	1 3 2005	strates Signatu	ILE TO	A STATE OF THE PARTY OF THE PAR						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 3:56 P™ ROMAN PAIGE APRIL 10 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL 4b. City, Town, or Location of Death Examiner BALTIMORE CITY N/A If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Min Hours 1 □XM 2 □ F Director 213 23 5712 1988 MARYLAND 16 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County re!, or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3322 MCELDERRY STREET 21205 U.S.A. filed within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2□ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify þ 3 □Widowed 4 □ Divorced BLACK "neturel", Completed 7 is marked other then "netur treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) I Hygiene. NIA 8th STUDENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 is marked o BENJAMIN PAIGE RENEA ROBINSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree 3322 MCELDERRY STREET BALTIMORE, MARYLAND 21205 RENEA PAIGE (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARKCEMETERY APR.14,2005 □Donation 5 □ Other (Specify) Baltimore, Md. 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME Signature of Funeral Service License 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 nadine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) NOW /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical SE FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown Š signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an page 2 s autopsy 2 □ No certificate 1 Yes 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 6 ☐Other (Specify) 2 1X Yes 2 No 1 Inpatient 3□ DOA this funeral Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Injury 5 1 Natural subject death. 1 Tes investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) st Magunest Street 4 Homicide tside 24 hours a 29a. Certifier t Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Common Physicien: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20 OCME APRIL 11, 2005 and address of person whi m 23a) (Type, Print) completed cause of de 111 Penn Street Baltimore, Maryland 21201 Registrar's Signature 31. Date filed

State

Registrar

2005

			1 - For State Registrar	State of Ma	aryland / Depa		of He	alth ar		tal Hyg	_	05	12513
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Las Edna Rob) 4a. Facility Name (If not institution, give	USON		4b City T	own. or l	ocation of I	d	Date of Death Month		Year 2005	3. Time of Death 2119 p M
	Examir Funeral Director	ier	UNIVERSITY of MARY 5. Social Security Number 6. Se	LAND MEDI	CAL SYSTEM (In yrs. last birthday) 66 Yrs.	If Under 1	AL.	M Ò If Under 24	Hrs. 8. C Min.	Date of Birth Month, Day, ARCH 6	N/	9. Birthpl Count	ace (State or Foreign ry) GINIA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other treumatic event, the Madical Eventrational be notified at ODGs.	To Be Completed by Funeral Director	10a. State 10b. County MARYLAND BALTIMOF 10e. Street and Number 3824 OFFUTT RD. 11. Marital Status 1 Never Married 2 Married 323Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12) 3rd grade 17. Father's Name (First, Middle, Last) CLEM MOSLEY SR. 19a. Informant's Name/Relationship (7) Henry Mosley/Brot 20a. Method of Disposition 1 235urial 2 Cremation 3 1 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licens	12. Was Decedent Armed Forces? 1 ☐ Yes 2 A If Yes, Give Year or Dates: ucation 1e completed) College (1-4or 5	Ever in U.S. 13. 16a. Decer (Give life.) +) 19b. Mailir 392 20b. Place of Dispocemetery, cref ST JAMES 22 W.	ALLSTC 10f. Zip C 211 Was Decede if Yes, specification of work bon NOT use TORY W and Address (4 Offu sition (Name matory or oth U.M.C. Name and	33 nt of Hisp y Cuban, YW Occupation done dur refired) ORKE 1. Street and of per place) Address C B	Specify: on ring most of the second s	Name (Fire NIA V or Rural Rote and 11 Date -13-0 COMMU	Yes or No- n, etc.) st, Middle, M CHAN tte Number, 1 st. W 2	Bla Specif 6b. Kind of B PERDUI laiden Suman NDLER City or Town, 0c. Location	What Count A. De America ck, White, e Sy: BLAC usiness/ind E CHIC ne) State, Zip 0 City or Tov	ck EN Code) RYLAND
68760,	Physician and /Medical Examiner and physician and physicia	ical Examiner	resulting in death) Last	a	the death. Do not ente. Tracheo. a consequence of):	er the mode of	gel	FIS +C	rdiac or res	piratory arre	st,		Approximate Interval Between Onset and Death
Vital Records, P.O. Box 68	Physiclen: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions co Color Nay Arthur Malle 25. Was case referred to medical examiner?	23c. If yes, outcome of the pregnant at 9 Unknown outributing to death but any of 15.04.	2 Fetal death 3 time of death 5 time of death 5 time.	Ectopic preg	se given	6. Place of	1 Death (Che	1 Yes 4a. Was an autopsy perform Yes 2 leck only one	Moderate Control of the Control of t	ribute to the 3 Probal Were autops prior to compleath?	cause of death? bly 4 Unknown sy findings available pletion of cause of
Division of	or Attending Physiter death. Director: After this in by the funeral dii	il Certification; To	27. Manney of Death 1	28a. Date of Injun (Month, Day 28e. Place of Injun building, etc	y Year) 28b. Time of Injury ry - At home, farm, stre (Specify)	M 28c	Injury at Work? 1 ☐ Yes	t s 2 □No	28d. I	Describe how ocation (Stre	once 6 Other (Specify) ow injury occurred freet and Number or Rural Route Number.		
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ORIGINAL

			1 - For State Registrar		aryland / Dep	artment of He	ealth and M	lental Hyg	iene	15	12514
ı	Physic		Decedent's Name (First, Middle, Sondra	Last)		Rolfes		2. Date of Dea Month	Day	Year	3. Time of Death 10:40 PM
	/Med Exami		4a. Facility Name (If not institution,			4b. City, Town, or I	Location of Death		4c. County	of Death	10;70 1
			FRANKLIN SQUARE	= HOSPITAL (CENTER	ROSE	DALE			ALTIMO	ORE
	Funeral Director		5. Social Security Number 219-32-3724 Usual Residence of Decedent	7. Ag	e (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day November	Year)		ace (State or Foreigr ry)
	ith the Maryland or 28e-f show	tor	MD. Baltimo	æ	10c. City, Town or L	ocation undalk				10	d. Inside City Limits
	h with the 23e or 28 at be not	Funeral Director	10e. Street and Number 8123 Dundalk Ave	enue		10f. Zip Code 21222		1	0g. Citizen of V	Vhat Count	ry?
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21215-0036	ithin 72 t ie. ien "nate Medica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion iring most of worki	ng	16b. Kind of Bu	siness/Indu	ustry
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Maryland	should I	2	Henry C. Bradsh 19a. Informant's Name/Relationship		19b. Maili	ng Address (Street an	Alpha D.		City or Town	State. Zin (Code)
	is 1 and 2 of Health a item 27 is other treu		Karen Reynolds 20a. Method of Disposition	Daughter	2330	Northclif:	fe Drive,	, Jarret	tsville	, MD.	21084
Baltimore,	82 = 5		1X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	cify)	Oak Lawn		200)5 D	undalk,	MD.	
Ba	permit. Par Department importent: any injury once.		21. Signature of Funeral Service Lic	C. Con	relly ?	Name and Address Connelly Fi 1110 Solle	of Facility Uneral HO rs Point	Ome Of D Road, D	undalk, undalk.	P.A. MD.	21222
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7112	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			2	6. Place of Death		-		
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	to the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	ledical	one)	thysician: To the best of aminer: On the basis of and manner state	examination and/or inv	occurred at the time, estigation, in my opini	date and place, ar on, death occurred	nd due to the cau d at the time, dat	se(s) and manr e and place, an	ner as state d due to th	ed. e cause(s)
	To the complet	Σ	29b. Signature and title of certifier	>		29c. License no		290	I. Date signed (Month, Day	y, Year)
16)71 "		30. Name and address of person who Dr - SUMMER ABDE 31. Date filed (Month, Day, Year)	completed cause of dea	ath (Item 23a) (Type, F	Print) NKLIDI SQL	IARE DRI	WE, BA	RTIMOR	E;t	1D 24237
	Sta Registr	te ar	APR 1	3 2005- 17	Signature						

December Name First Middle, Last Name First Middle, Makes Summer Name Fi				For State Registrer	State of Ma	aryland	•	irtment of He tificate of D		nentai Hy	/gien Reg. N		
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Physician / Medical Examiner To grant and the property of the property of condition of the property of the pr	Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice	nsee A		1 16	Name and Address	S Of Facility HO	WELL F	UNE	RAL HO	ME 21207
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Sequentially list conditions, it is conditionally as a consequence of: Constitute Constitut				resulting in death)	0				more than				
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The part of the pa		cuted nd ransit	amin	causé. Enter Undertying Cause (Disease or injury that initiated events									3 weeks
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Second S		that the			contributing to death b	ut not resul	ting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Second S	rds	quires an sign	ed b								Yes :	2 □ No 3 □ Pr	robably 4 Unknown
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Second S	/ita	cien: ertifica ector, p	a					0.1		th (Check only	one)		
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Co Raymond Zhu, MD D0056143 4/11/05	On	th. : After	ition	1 XNatural 5 ☐ Pending	(Month, Da	y Year)		Work	?			.,	
Co Raymond Zhu, MD D0056143 4/11/05	Divisi	l or Atter after dea Director	ertifica	3 ☐ Suicide 6 ☐ Could not I	200. Flace of III	ury - At hon c. (Specify)	ne, farm, sti	eet, factory, office					ural Route Number,
Co Raymond Zhu, MD D0056143 4/11/05		e Hospite 124 hours le Funerel		(Check only 2 Medical Exa	miner: On the basis o	f examination							
		To th withir To th comp	Me	•	. 20					211			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W, RAYMOND 2HU, MD. ST. AGNES HEALTHCARE, 900 CATON AVENUE, BALTIMORE, MD) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 3 2005		1,	CO. Kaymond Zhu, NO DO056143										
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	_	1		W, RAYMOND 2HU, A	completed cause of $D \cdot ST$. AC	RNES	23a) (Type, HEALT	Print) THCARE,	700 CATC	NAVEA	IUE,	BALTIMON	RE, MD 11229
	4.			31. Date filed (Month, Day, Year) 32. Registrar's Signature									

RICKS, REDDICK

			For State	State of Maryland		ment of He			2005	12516
			Registrar 1. Decedent's Name (First, Middle, Li	ast)	Oerui	icate of De	Calli	2. Date of Death	No.	3. Time of Death
	Physici		TI	R	Ran	dall		Month	Day Year	745 AM
>	/Medic Examir		4a. Facility Name (If not institution, gi	ve street and number)	4t	. City, Town, or Lo	ocation of Death		4c. County of Deal	n NIA
			Future Care	Homewood		130	alto			
	Funeral		0.0	Sex 7. Age (In yrs. la	M		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
	Director	ļ	Usual Residence of Decedent	64	Yrs.			July 17, 1	1940	Chio
	land ow		10a. State 10b. County N	1A 10c. City.	, Town or Locati	on				10d. Inside City Limits
	Man a-f sh	ţò	MD		Ba	Itimo	VP.			1 Pres 2 No
	th the or 28,	Director	10e. Street and Number			Of. Zip Code		10g.	Citizen of What Co	untry?
	ath wi		2701 Nor	shire		31	930		USA	
	ar dez	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was	Decedent of Hispa s, specify Cuban, I	anic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	ours after death with the Marylan rat', or itams 23a or 28a-f show Examiner must be indiffed at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 🗆	Yes 24No 3	Specify:		Specify:	Slack
5-0036	n 72 hours after death with the Maryland "natural", or itams 23a or 28a-f show adjeal Examinar must be notified at	ed	15. Decedent's E	Education	16a. Decedent	s Usual Occupation	on	168	o. Kind of Business/	Industry
215	S 9	Completed	(Specify only highest gi	rade completed) College (1-4or 5+)	(Give kind life. DO l	of work done duri NOT use retired)	ing most of working	ng .	^	. \
2121	filed with Hygiene. other thar	Con				Paint	797		Lomn	nercial
Maryland	be od o	Be	17. Father's Name (First, Middle, Las	" D 1	11	18	3. Mother's Name	(First, Middle, Mai	den Sumame)	
Z Z	d 2 should th and Men 7 is marke traumatic	2	19a. Informant's Name/Relationship	(Type Print)	10h Mailing A	ddroon /Stroot and	1 - THY	/ WOI	IJUCK ity or Town, State, 2	ria Carda N
Ma	nd 2 sho lith and 27 is ma		Althia A. Ran	dall wife	2701		Live P	Adule Number, C	Ly of Town, State, 2	Ip Code)
re,	s 1 and if Healt itam 2 other		20a. Method of Disposition	20b. Pla	ace of Dispositio	n (Name of ry or other place)	Di	ate 200	Location - City or	Town, State
E	9 = 5		1 Burial 2 Cremation 3 (`4 Donation 5 Other (Spec	THemoval from State	T -	YN	4-11	5-05 S	3-140	am.
Baltimore	permit. Pag Department Important: any njury o		21. Signature Funeral Service Lice	insee		me and Address of	of Facility		Citio	21269
_	Dep limp		Jenod to.	1 harch	Go	xy P Ma	irch F/H	270 Fred	hilton Pas	s Balto, mD
			23a. Part1 Enter the disease, or con shock, or heart failure. List only	nplications that caused the death. one cause on each line.	Do not enter th	e mode of dying, s	such as cardiac or	respiratory arrest,		Approximate Interval Between
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSC	LEROTIC	- condi	oyas w	ier dis	ense	Onset and Death
	Examiner		Tooland in doubly	Due to (or as a conseque	ence of):					
	10.	ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (r as a conseque						C. C. Co.
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	a Conscative	. \	- Fei	201			Untrough
o o	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseque						
8760	ate hy: the	edicai		d. End Stuge	Rese	Q Dise	ense			Unknown
9	death certific e attending p id for use as i	/Med	IF FEMALE:	23c. If yes, outcome of pregnan	a.					
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3 □Ect	opic pregnancy ner (specify)			23d. Date of deli Month	very Day Year
o.	at the de by the tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		(3)00///				
s, P	requires that the een signed by th hould be detache	by P	Part II. Dther significant conditions	contributing to death but not result	ting in the under	lying cause given i	in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ğ	w require been sig should b							1 Tes	2 □ No 3 □ Pro	obably 4 Unknown
Vital Record	law as b 2 sl	ompieted						24a. Was an autopsy		topsy findings available ompletion of cause of
<u> </u>	Th ate pag	Con						performed 1 ☐ Yes 2 ☑	death?	2 No
Vita	Physician: Th this certificate al director, paç	Be	25. Was case referred to medical examiner?	Hospital:			6. Place of Death	Check onl one		
of		- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	T □ Inpatient 2 □ E	P/Outpatient 3	DOA Other:		e 5 Residence	6 Other (Spec	ity)
	Attanding Ph or death. actor: After thi by the funeral	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes	2 □ No	od. Doscribe now i	njury occurred	
Division	or Attan after deatl Diractor: in by the	ertification:	3 Suicide 6 Could not to determined	28e. Place of Injury - At hom	ne, farm, street,	factory, office	21	Bf. Location (Street	and Number or Ru	ral Route Number,
	spital or Attan ours after deat seral Diractor: filled in by the	Cert	4 Tromeide	building, etc. (Specify)				City or Town, Si	rare)	
	Fur 4 h	edical	Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examination	ledge, death occorn and/or investi	urred at the time,	date and place, ar	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To tha Hos within 24 h To tha Fur completely	Med	one)	and manner stated.				00.1		
	F 3 F 8		108	completed cause of death (Item 2) 32. Registar's Signature 3 2005		7	0251	230.	illiania	my, rusij
1	21		30. Name and address of person who	completed cause of death (Item :	23a) (Type, Print	1)005	4020	,	1112/05	
	2"		DALJEET S.	Salvia MO	160	o west	MT RO	yal Avo	Prest	MO 21217
	Sta		31. Date filed (Month, Day, Year)	32. Register's Signatu	ire	L. H.	. I day	1	The state of the s	· · · · · · · · /
	Registr	ar	APR 1	3 2005 Blown	15 14					

			1 - State Amend Item 8 p	State of Marylar Der flu G842	d / Depa -13-05 Cei	artment of H Las tificate of L	ealth a Death	ind Me	ental Hy	giene Reg. No. 2 (005	12	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)						2. Date of De Month MOVC	Day 1 29	2005	3. Time of	Death M
	Examin Funeral	er	4a. Facility Name (If not institution, give str MOVTNWeS+ 5. Social Security Number 6. Sex	ospital Ce	N+EV last birthday)	4b. City, Town, or COUCL If Under 1 Year Months Days	If Under 2	oun	8. Date of Bir	Ba	y of Death		or Foreign
	Director		Usual Residence of Decedent	W 2□F S	(Yrs.		Hours	Min.	3 24	1414	l No	C	
	death with the Maryland ms 23e or 28e-f show	ctor	MD NA		y, Town or Lo						10	od. Inside Ci 1 XYes	ity Limits 2 No
	with th	Director	10e. Street and Number	- 3		10f. Zip Code	212			10g. Citizen of	What Count	try?	
2-nn3p	n 72 hours after death with the Marylan "natural", or Items 23e or 28e-f show caffed Ever ill et i until be notified at	ted by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa	2. Was Decedent Ever in U Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates:	16a. Dece	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☑ No dent's Usual Occupa	Specify:				ice - America ack, White, e ify:	ack	
7	within 7 iene. than "r	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d DO NOT use retired)))	or workin	g	c	7. to	0	
7 0	filed Hyg ther ant,	Be Co	9th grade 17. Father's Name (First, Middle, Last)	na	L a	borer	18. Mothe	r's Name	(First, Middle	Beth S , Maiden Suma		Corp) •
/land	D to D	ToB	Jethron Stokes				Hatt	ie C	oggin	ıs			
Mar	12 sho h and I 7 Is me treums		19a. Informant's Name/Relationship (Type Georgia Stokes-Wi			ng Address <i>(Street a</i> Centmill							1208
a)	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marka any injury or othar treumatic <u>once.</u>	1	20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other place		Da		20c. Location			
Ē	Pages nent of I ant: If it ury or o		1 🖫 Burial 2 □ Cremation 3 □ Rer '4 □ Donation 5 □ Other (Specify)	moval from State		Forest	· 1	. 4/	5/05	Owing	gs Mi	lls,	Md
Saltimor	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	Stora) Ma	Name and Addres	s of Facility Wes	t		17.7775.57	oras s		_
	407.40		291. Part1. Enter the disease, reamo ica	ations that caused the deat		OU waba						21215 Approximat	e
	Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)			votic cu sum	avdi	ιοριι	lmene	ary di	sease	Interval Bet Onset and I	ween Death
avon,	icate be executed physician and s the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or as a consequence)									
O. BOX 6	death certif s attending d for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	I death 3	Ectopic pregnancy Other (specify)					ate of deliver	-	Year
as, r	Se G	by	Part II. Other significant conditions control Anemia	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did t	tobacco use cor Yes 2 ☐ No		e cause of dalatic	
Records	The law ate has b page 2 sl	Completed	Pulmonary Chronic re	embolism nal fai			24a. Was auto perfo		Were autop prior to com death? 1 \(\sum \text{Yes} \)	pletion of c	available ause of		
VItal		o Be	25. Was case referred to medical examiner?	spital:	150/0	Othe			(Check only				
lon or	ding h. After fune	1-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 L Nui	28		dence 6 Ot how injury occu)	
DIVISION	i Diffe	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	eet, factory, office		21	8f. Location (City or To	Street and Num wn, State)	ber or Rural	Route Num	ber,
	Hos H Pure	edica (cian: To the best of my known: On the basis of examination and manner stated.									:)
	within 2 To the	ž	29b. Signature and title of certifier	· M1 0 ~1	11111/	29c. License	205	7 7		29d. Date sign			
10			30. Name and address of person who com	M MUUA	n 23a) (Type.	Print)	005	4+6	00	Marcl	129,	2005)
1) Sta	ite	5401 Old COU 31. Date filed (Month, Day, Year)	V+ KOQQ 32. Registrats Signa	Ka Ma	dallstow	n, L	ro.	2113	3 ERI	CA TO	BIN MU	HD
	Registr		APR 1	3 2005 Blow	KI SS	Maria							

			Please			k Indelible Ink		•	9	e.
			1 - For State Registrar	State of Ma	aryland / I	Department of F Certificate of			jiene _{eg. No.} 200	5 12519
	Physici		Decedent's Name (First, Middle, Last EVERLENA	WHITE	SINKLE	ZR .		2. Date of Dear	th Day Ye	
	/Medic	er	4a. Facility Name (If not institution, give Sina Hospits 5. Social Security Number 6. S	al of B	altmo(e Baltin	If Under 24 Hrs.	/	4c. County of E	
	Funeral Director			□M 2 X F	86	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day) 01/09	/1919 S	Country) OUTH CAROLIN
	death with the Maryland ims 23a or 28a-f show f inter the profifficol at	tor	MD 10b. County N/A		10c. City, Tow BAI	n or Location TIMORE CI	TY			10d. Inside City Limits Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 4511 PROSPEC	T CIRCLE		10f. Zip Code 21 21	6	1	0g. Citizen of What	t Country?
920	n 72 hours after death with the Maryla "natural", or Items 23s or 28s-1 shov efficel Examinat nust be rediffed at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes If Yes, Give Year or Dates:		13. Was Decedent of HI Yes, specify Cub	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. BLACK
21215-0036	within 72 ho ene. than "natur the Medical.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of worki d)	ing	16b. Kind of Busine	·
nd 2	al Hygie d other t vent,	Be Co	8TH 17. Father's Name (First, Middle, Last)			COOK	18. Mother's Name	(First, Middle, i		NDUSTRY
Maryland	2 should be and Mental is marked c	To	EDWARD WHITE 19a. Informant's Name/Relationship (104	D. Mailing Address (Street	HATTI			to Zin Code l
	2 4 E S		AMELIA CUMMING		ER 4	1511 PROSP	ECT CIRC	LE, BA	LTIMORE	, MD 21216
Baltimore	00		20a. Method of Disposition **X**Burial 2			of Disposition (Name of lry, crematory or other pla ZION CEM.			20c. Location - City BALTIMO	
Balt	Peri Dep any		21. Signature of Vineral Service Licer 23a. Phyl. Enfer the distract, or come shock, or bear failure. List only	plications that caused one cause on each li		not enter the mode of dyl	ERTY HGH ng, such as cardiac o	TS AVE	BALT	HOME 21207 IMORE, MD Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequence	emic ca on: ension	rdiom	yo pat	ny	5 years 10 years
68760,	death certificate be executed e attending physicien and of for use as the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. hyp	à cui seguettos	pidem	ia			10 years
P.O. Box 6	that the death certificate ed by the attending physi detached for use as the I	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	a 3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	delivery Day Year
	s un o	d by PI	Part II. Other significant conditions of	ontributing to death b	ut not resulting i	in the underlying cause gn	ven in Part I.			e to the cause of death? Probably 4 Unknown
of Vital Records,	The law ate has b page 2 si	Completed	OF What was the state of the st						ned? deati 2☑ No 1☐	a autopsy findings available to completion of cause of h? Yes 21 No
ion of Vit	ng Phys fter this ineral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		Time of 28c. Injury Wo	ry at	me 5 Reside	e) ence 6 □Other (S ow injury occurred	Specify)
Division	al or Atte s after dea il Directo	Certification:	3 Suicide 6 Could not be determined	288. Place of Inf	ury - At home, fa c. <i>(Specify)</i>	arm, street, factory, office	1	28f. Location (St City or Town	reet and Number of n, State)	r Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination ar	e, death occurred at the tind/or investigation, in my o	me, date and place, a opinion, death occurre	and due to the ca ed at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
)	To t Withi	Σ	29b. Signature and title of certifier	200		29c. Licens			9d. Date signed (M	
10-1	b		30. N car and address of person who	completed cause of d	leath (Item 23a)	(Type, Print) Sin	ai Hos	spita	1 of ,	Baltimore
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 3 2	nderso 32. Pogistr	ar's Signature	Sparle				

Storm Feltz, Mildred Baltimore, Maryland 21215-0036

			1 _ For State	State of Maryland / Depa	artment of Health and IV rtificate of Death		2000	1 1 10 10 10
			Registrar 1. Decedent's Name (First, Middle, Last		Tillicate of Death	2. Date of Deat	eg. No.C., UU	3. Time of Death
	Physici			comfeltz		Month	Day Yea	r M
	/Medic Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	APRIL	11 2005 4c. County of De	
	LXdiiii		GREATER BALTIMORE	MEDICAL CENTER	TOWSON		BALTIMO	RE
	Funeral		5. Social Security Number 6. Se	THE OF	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	inthplace (State or Foreign Country)
	Director		213 10 3356 Usual Residence of Decedent	x 92 Yrs.		January 1	3 1913 Ba	ltimore City, N
	/land		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Man,	tor	Maryland Baltimore	Baltimore Co	ountv			1 ☐ Yes 2 ☐ No X
	or 28	Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What (Country?
	ath w	ral	2910 Garet Road		21234		USA	
	ltams	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Hace - An Black, Wi	nerican Indian, nite, etc.
39	urs af	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: W	hite
21215-0036	72 hours after death with the Maryland Insturet, or Itams 23s or 28s-f show Jisal Exacited eath be rediffed at	ted	15. Decedent's Edu (Specify only highest grad	cation 16a. Dece	dent's Usual Occupation kind of work done during most of work	ina	16b. Kind of Busines	s/Industry
2	C * 18	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	9		
	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)	N/A Clerk	18. Mother's Name		US Governme	nt
au	d be de antal l	To Be	Thamas E Dorsev		Nellie V		naidon demanio,	
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. itam 27 Is markad other than othar treumetic avant, It a M	F	19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Mailir	ng Address (Street and Number or Run		City or Town, State	, Zip Code)
	D € 72 T		Betty Buffington		Falls Mont Drive Fall	ston, Md.	21047	
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)	Date	20c. Location - City of	or Town, State
ti H	permit. Pages Department of Importent: If if any injury or c		*4 Donation 5 Dother (Specify)	Gardens of	Faith Cem. April 15	2005 E	altimore, M	aryland
Bal	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens		t. Name and Address of Facility .assahn Funeral Home II	nc		
			23a. Part1. Enter the disease, or comp	ications that caused the death. Do not ent	401 Belair Road Baltir er the mode of dying, such as cardiac	nore, Mi.	21236	Approximate
	Pnysician		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line. ACUTE CON		and		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):				Month
И	Examiner		Sequentially list conditions.	J	c CARDIC	o My	PATH	*
	ed sit	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			7.	
	executed and al-transit		that initiated events resulting in death) Last	Due to (or as a consequence of):				
68760,	certificate be exinding physician are as the burial.	cal E	· ·	1				
9	. E O α	Physician/Medical						
Вох	attendin for use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of d	elivery Day Year
	the at	/sici	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 5□ 9□Unknown	Other (specify)		Worth	Day Tour
P.0	The law requires that the death the has been signed by the atter bage 2 should be detached for L			ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	uires n sign lld be	d by				1 □ Ye	s 2 No 3 1	Probably 4 Dinknown
000	law require as been si 2 should b	olete				24a. Was a		autopsy findings available
Re	The la	Completed				autops perform		
Vital Records,	yaician: Th ils certificate director, pag	Bec	25. Was case referred to medical examiner?		26. Place of Death			
of \	d is	은	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 X R/Outpatien			nce 6 Other (Sp	ecify)
	Jing After fune	tion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Division	or Attanding after death. Diractor: After in by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str		28f. Location (St	reet and Number or I	Rural Route Number,
<u> </u>	in the	Certification;	4 - Homicide determined	building, etc. (Specify)		City or Town	, State)	
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edicai (29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the ca	use(s) and manner a	as stated.
	the hin 24 the F	Medi	one)	and manner stated.				
į	L M L	2	29b. Signature and title of certifier	losella : m	29c. License number	$G = \begin{bmatrix} 2 \\ 2 \end{bmatrix}$	9d. Date signed (<i>Moi</i>	, Day, 1941)
1	11	e d	30. Name and address of person who co	empleted cause of death (Item 23a) (Type,	Print) —	/	, ,,,	-
1			4	MD 7600 OSL	ER Dr. You	SON 1	40 21	204
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature				
	Registr	ar	APR 1 3 200	15 Hours It Does	MEL			

DHMH 17 Rev 1/2001

			_ For	State of M	aryland	/ Depa	ırtment	of He	alth and M	lental Hyg	giene	nns	10501
			1 - State Registrar AMEND TTEM 3 1. Decedent's Name (First, Middle, Last	3 PER PH	Y G842	4449	ungare	PID	eatri	2. Date of Dea	Reg. No."	. 000	3 Time of Dooth
	Physici	an								Month	Day		3. Time of Death 9:55am
	/Medi		Queen Esther Smit 4a. Facility Name (If not institution, give		_		4b. City. To	own, or la	ocation of Death	April 2		005 County of Dea	ath
	Examir	ier	911 Leadenhall St						Baltimor	<u>.</u>			N/A
	Funeral		5. Social Security Number 6. Se	x 7. Ag	ge (In yrs. las		If Under 1	Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	(Voar)	9. Bi	irthplace (State or Foreign Country)
	Director		217-52-6622]M 2∭F	55	Yrs.	Months	Days	Hours Min.	(Month, Day Dec. 11	, 19	949 V	irginia
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation						10d. Inside City Limits
	haryla e d el	5	MD N/	΄ Δ			Baltin	ore					ty∐Yes 2 □ No
	28e-i	ect	10e. Street and Number				10f. Zip C				10a. Citiz	en of What C	Country?
	3e or		911 Leadenhall St	reet, Apt	509			212	230			nited S	
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 ehow he Medical Examirer must be recitied at	Funeral Director		12. Was Decedent	Ever in U.S.		Vas Decede		anic Origin? (Sp. Mexican, Puerto	acify Yes or No-		4. Race - Am	erican Indian,
ထ္	after or Ite	Ē	1X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give	No		r Yes, specin □ Yes 2	_		Hican, etc.)		Black, Wh	ite, etc. Black
Maryland 21215-0036	urel',	d by	3 Widowed 4 Divorced	Year or Dates:			163 26		Opechy.			Specify:	
5	"net	Completed	15. Decedent's Edu (Specify only highest grad	ication le <i>completed)</i>		16a. Deced	lent's Usual kind of work	done dui	on ring most of work	ing		d of Busines:	•
12	withir ane. then	g.	Elementary/Secondary (0-12)	College (1-4or	5+)		lerk	retired)					Security Cration
р 5	filed Hygi sther		17. Father's Name (First, Middle, Last)			<u> </u>	LEIK	1	8. Mother's Name	e (First, Middle,			lation
an	ld be entat ked c	To Be	Willie Smith						Carrie	Smith			
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailin	g Address (Street and	d Number or Rura		r, City or	Town, State,	Zip Code)
Σ	and 2		Katerina Rodrigu	ez Daugł	nter	911 1	Leaden	hall	Street	Apt. 5	09,	Balt.,	MD 21230
ore	of He fiten r oth		20a. Method of Disposition XBurial 2 Cremation 3 F	Removal from State	20b. Pla	ce of Dispos	sition (Name atory or oth	of er place)		Date	20c. Loc	cation - City o	r Town, State
Ĕ	Pag ment ent: I ury o	/	^ 4 □Donation 5 □Other (Specify)		(Cem	etery						klyn,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f ehow any injury or other treumatic event, the Medical Examinet must be notified at ance.	(21 Signature of Funeral Service Licens	PAA.	A	22	. Name and	Address	of FacilityAmb 1	ose Fun	era1	Home,	Inc.
_	40 = € Ø		Common !	CON		132	28 Su1	phur	Spring	Rd., Ar	butu	s, MD	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ne cause on each li	ine.	Do not ente	er the mode	graying,	such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. / U	tus	tall	1	N	ust 1	WILL	<u> </u>		3 /2 yr-3
L	Examiner			Due to (or as	a conseque	nce of):							/
	_	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	nce of):							
	te be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
760,	e exe ian ar urial-t		resulting in death) Last	Due to (or as	a conseque	nce of);							
876	icate be executed physician and s the burial-transit	dical		d		-			<u>.</u>				
x 68	that the death certifical ed by the attending phy detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of prognance	~							
Вох	attend for us	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	eath 3	Ectopic pred				2	3d. Date of de Month	Day Year
o.	the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	1 11110 01 000	30	TOTTION (Spec						
Δ,	s that	by Pr	Part II. Other significant conditions con	ntributing to death b	out not resulti	ing in the un	iderlying cau	ise given	in Part I.	23e. Did to	bacoo us	contribute t	to the cause of death?
Vital Records,	The law requires ate has been sign bage 2 should be	q pa								1 🗆 Y	es 🗡	No 3□P	robably 4 Unknown
000	aw requ s been 2 shoule	Completed								24a. Was a		24b. Were a	utopsy findings available
m	The la	mo								autops perfor	Tied?	death?	
ita		BeC	25. Was case referred to medical examiner?					2	6. Place of Death				
of <	Physicien: r this certific ral director,	To	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		R/Outpatient		Other:	4 Nursing Ho	ne / 5 Reside	ence 6	□Other (Spe	ecify)
	ding Physicien: h. After this certific funeral director,		27. Manner of Death 1. ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 2	8b. Time of Injury		. Injury at Work?		28d. Describe ho	ow injury	occurred	
Sio	Attending r death. sctor: Afte	cat	2 Accident investigation 3 Suicide 6 Could not be	On Place of Ini		- 4	M		s 2 No	20f Location /Cr	lmat and	Alimahasas	lural Route Number,
Division	or Al after of Direction by	Certification:	4 Homicide determined	28e. Place of Inj building, et	c. (Specify)	e, rarm, stre	eet, ractory, o	опісе		City or Town		NUMBER OF A	lurar Aoute Number,
_	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physics	sician: To the best	of my knowle	edge, death	occurred at	the time.	date and place.	and due to the c	ause(s) a	and manner a	s stated.
	ne Ho ne Fui ietely	Medical	(Check only 2 Medical Exami	ner: On the basis o and manner st	f examination	n and/or inv	estigation, in	my opin	ion, death occurr	ed at the time, d	ate and p	place, and du	e to the cause(s)
	To the within 2 To the complet	7	29b. Signature and title of certifier	DNCI	YOV	111	290	icense n	jumber /	9 2	9d. Date	signed (Mon	th, Day, Year)
	1					1	1	XX	17671	1	0	4/07	103
1.	1	-	30. Name and address dyperson who co	impleted cause of c	leath (Item 2	3a) (Type, F	Print)	, 0				1	11
1			Kobert Ubnega	051	04 K	both	Char	les	St. Sui	te 205	Ne:	st Balt	a Md 21204
	Sta Registr		31. Date filed (Month, Day, Year) \(\sqrt{9} \)	32. Registr	ar's Signatur	Laste							ŧ

						nd / Dep	partment of Fertificate of	lealth and I	Mental Hy	giene Reg. No.	05	1252	22		
		Physici	an	Decedent's Name (First, Middle, Last) CHTDLEV	C		СПУ	VITZ	2. Date of De	Day	Year	3. Time of D	P M		
		/Medic	al	SHIRLEY 4a. Facility Name (If not institution, give street and	G.			r Location of Death	April		ty of Death	7.01			
		Examin	er		Baltim	ore	Baltime				.,	N/A			
		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs				8. Date of Bir Month, Da DEC. 31	th av. Yearl	9. Birthp	lace (State or	Foreign		
		Director		219-10-8925 1 ¹ M ² X F	8	1 Yrs.			DEC.31	,1923		Ol	Н		
		land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or	Location				1	0d. Inside City	Limits		
		Mary I-f sh	tor	MD N/A		BAL	TIMORE					¹ X Yes 3	2 🗌 No		
		th the)irec	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	itry?			
		s 23a	Funeral Director	3011 FALLSTAFF ROAD #				21209		146		USA			
		ter de Itams Frank	nne	Armed	ecedent Ever in l Forces? s 2 M No	J.S. 13	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S) an, Mexican, Puerti	pecity Yes or No o Rican, etc.)	5- 14. Hi	ace - Americ lack, White,	etc.			
	036	al', or	þ	3 ☐ Widowed 4 ☐ Divorced Year of	s 2 💢 No Give Dates:		1☐ Yes 2【X No	Specify:		Spec	cify:	WHITE			
	5-0	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show thit, the Medical Eraminal must be notified at	Be Completed	15. Decedent's Education (Specify only highest grade complete	d)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retire	pation during most of wor	king	16b. Kind of	Business/In	dustry			
	121	within ane. than '	ldm	Elementary/Secondary (0-12) College	(1-4or 5+)	1	RETARY	d)		SOCIAL	SECUR	ITV ADM	MTN		
	d 2	filed Hygie other ent, I	ပိ	17. Father's Name (First, Middle, Last)		320	IXE I / IXI	18. Mother's Nam	ne (First, Middle			111 /101	12110		
1	lan	should be filed withir nd Mental Hygiene. marked other than imatic avent, tre M	To B	MAX		GUT	HOFF	IDA				HANKI	N		
Shirke	Maryland 21215-0036	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (Type, Print)			iling Address (Street			-			00		
3	ດົ	1 and 1 Health am 27		WILLIAM B. SHAVITZ /	HUSBAND	_	1 FALLSTA position (Name of	FF KUAD #	FIU5-A Date	BALIIN 20c. Location		MD 2120	J9		
- 4	Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar most be notified at Once.		1 🛣 Burial 2 □ Cremation 3 □ Removal fro '4 □ Donation 5 □ Other (Specify)	m State	cemetery, cr	ematory or other place UNAH-AITZ					PE, MD			
4	量	artme or en injury		21. Signature of Funeral Service Licensee	/AIV		22. Name and Addre		The second secon						
havi	ä	Depa Impo any ir		Day Clark		EY.	8900 REIS	TERSTOWN	ROAD -	PIKESVI			38		
74			10110	23a. Part . Enter the diseal 4, or complications the style of the cause of the complex cause of the complex cause of the c	it caused the dea n each line.	th. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Betwee Onset and De	een		
		Physician	9.3	Immediate Cause (Final disease or condition resulting in death)	Imon	ay	cmbol	ism				2 da	15		
		/Medical Examiner		Due to (or as a consequence of): ACD 444 Pichet to 1. ft Shillingt											
			lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a conse	quence of):	7011 10	Left -	· ice i j			vije 1	7.77		
	X	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
	,092	be exe	cal Ex	Due	or (or as a conse	quence or):					*				
	687	death certificate b attending physic of for use as the b		d											
	XO	Attending Physician: The law requires that the death certifica r death. actor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	by Physician/Med	23b. was decedent pregnant	outcome of pregree birth 2 - Fet		☐Ectopic pregnance	,			ate of delive	-			
	O. B	the att	sicia		gnant at time of		Other (specify)			N	Month	Day Ye	M		
	Division of Vital Records, P.O. Box	es that the death cer igned by the attendin be detached for use	Phy	Part II. Dther significant conditions contributing to	death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute to th	e cause of dea	ath?		
	ds,	urres tha signed I	d by	Hypertension					1 🗆	Yes 2 No	3 Prob	ably 4 □Un	nknown		
	000	aw requir s been s 2 should	Completed	,					24a. Was	an 24b	. Were auto	osy findings av	vailable		
	Re	The la ate ha	om						auto perfo	ormed?	death?	Mo No	128 01		
	/ita	cian: ertifica	Be	25. Was case referred to medical examiner?			100	26. Place of Dea	th (Check only	one)					
	of)	ding Physician: The lav h. Atter this certificate has funeral director, page 2	2			ER/Outpati		4 Nursing n	ome 5 Resi	dence 6 🗆 O		′)			
	O	ding th. After funer	Certification;	i Natural 5 Pending 2 Accident Investigation	te of Injury onth, Day Year)	Injury	Wor	k? Yes 2 □ No	Edd. Deddribe	now injury cook	21100				
	Visi	Attendi ar death. actor; A by the fu	ifica	3 Suicide 6 Could not be	ce of Injury - At h	nome, farm, s	street, factory, office		28f. Location (City or To	Street and Nun	nber or Rura	I Route Numbe	er,		
		itel or rs afte ral Dir led in	Cert												
		To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) Lack Certifying Physician: To 2 Medicel Exeminer: On the and m	basis of examin	owledge, dea ation and/or	ath occurred at the til investigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and n date and place	nanner as st e, and due to	ated. the cause(s)			
		o the ithin 2 o tha	Med	29b. Signature and title of certifier	anner stated.		29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)			
		- 5 - 0		Rolf Krenk,	MP		RE	5-00	00	April	9,	2005	-		
		5		30. Name and address of person who completed of ROUF KREUTE, MU		m 23a) (Type	e, Print)	P B	(./ ' -	-					
		1			. Registrar's Sign		spital	of Ba	ITIMO	KE					
		Sta Registr			48		1								
	DH	MH 17 Rev 1/2	001	1111 1 0 2003	Estera ,	5 19									
						ORIGIN	IAL								

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

NANAW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORHNDO B

ORIGINAL SPENIE

Division o	To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	Constitution of the state of th
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ř	St Regist	ate tra
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			Please	State of Maryla				•	_	ibie.	
					Ce	ertificate of	Death		Reg. No.	Ph pro	1 m m m 1
			1. Decedent's Name (First, Middle, La	st)				2. Date of De		JJ	3. Time of Death
<u>,</u>	Physic /Medi Exami	ical	WILLIAM 4a. Facility Name (If not institution, giv.		TYLER,	JR.	4b. City, Town, or L	Month April ocation of Death		Year 2005 by of Death	5:13 PM
	LAGITIII	1101	McCready Memori	al Hospital			Crisfi	eld	S	omerse	et.
F	uneral		5. Social Security Number 6. S	ex 7. Age (In yı	s. last birthday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da			lace (State or Foreign try)
	irector		214-34-7915	XM 2□F	68 Yrs.	Workins Days	Tiodis Will.		7 17, 193		yland
Б	>		Usual Residence of Decedent 10a. State 10b. County	100 /	City, Town or L	coation				14	Od Jasida City Limite
aryla	sho a	<u>_</u>		100.	olly, TOWN OF L	ocation				10	0d. Inside City Limits 1 □XYes 2 □ No
he N	28e-f	Director	Maryland Somer	set		10f. Zip Code	Crisfield	<u>d</u>	10g. Citizen of	Min of Court	
death with the Maryland	al', or items 23e or 28e-f show Examiner must be notified at								rog. Citizen of	what Count	,ı y r
eath	18 23	Funeral	5 Standard Avenue	12. Was Decedent Ever in	US 13		21817 Hispanic Origin? (So	ecity Yes or No	14 Rac	USA ce - America	an Indian
_ ē	ie ie	ᆵ	1 Never Married 2 Married	Armed Forces?	56-		Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bla	ick, White, e	
5-UUZU 72 hours after	o La	5	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 196	_	1 ☐ Yes 2 🖾 No	Specify:		Specif	_{fy:} Whi	te
5-0 -0	"netural", odical Ex	Completed	15. Decedent's Ed	lucation		edent's Usual Occu	pation	in a	16b. Kind of B	lusiness/Ind	ustry
within 7	. L. N	를	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retire	pation during most of work id)	ang	Paint	tbrush	1
N be will	1	등	12			Brush Ma	aker		Manui	factur	er
	d other event,	ag a	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surnar	ne)	
V Suld to	arke	ဥ	William Hance Tyl	er			Agnes E.				
2 sh	is in the second		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mail	ing Address (Street	and Number or Rur	al Route Numbe	er, City or Town	, State, Zip (Code)
and and	item 27 other to		Ricky Arndt (Son)	201	5 St	andard Av	zenue – Cr				
Pages 1	or of		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	osition (Name of ematory or other pla	ce)	Date	20c. Location -	· City or Tow	vπ, State
t. Pages	lury in		4 ☐ Donation 5 ☐ Other (Specify				ial Park 4	1/9/05	Crisfiel	ld, Ma	ryland
Den II	important: if item any injury or othe once.		21. Signature of Funeral Service Licen	900 Kar 605		2. Name and Addre	ess of Facility & SONS Fu	meral F	iono∈		-
م م	1 .= « O		Mary Beth Bra	dshaw-Pruitt						Maryl	and 21817
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the de						(F)	Approximate Interval Between
***	sician				-	- 1		/			Onset and Death
	edical miner		Immediate Cause (Final disease or condition resulting in death)	a. Emos	Maye	Puln	way 1-	abros	15	1-	Zyens
		<u>.</u>	resulting in death)		(or as a conse						
pe	sit	cal Examiner		b							
ou, be executed	sician end buńel-transit	xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):					
8 8	ician	alE	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
icete	× 9	=	resulting in death) Last	Due to	or as a conse	quence of):				1	
Certii	ding ISO O	by Physician/Med		d							
ea t	d for u	Clai	Contil Other cirmitisant conditions on	maribustics to double but and and			on in One I	anh Dida	-h		the cause of death?
1 §	y the	hys	Part II. Other significant conditions co	intributing to death but not re	suling in the t	indenying cause giv	en in Fait i.		obacco usa con fas 2□ No	_	the causa of death?
s that	ned be det	y P	CHACOT To	od Deform	1172			'''	183 20110	0,000	151) 4 d o i i i i i i
dire	n sig uld b			U	0			24a. Was	an autopsy med?	24b. Wer	e autopsy findings lable prior to
2	s bee	Set						penor	meu :	com of de	pletion of cause eath?
he la	age 2	Completed						1 D Y	es 2110	10	/
	tificet tor, p	Be C	25. Was case referred to medical				26. Place of Death				
ysici	s cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth				er (Specify)	
- E	er th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor			ow injury occur		
agi e	r: Aft	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Moran, Day rour)	injuly		Yes 2 □ No				
Atte er de	by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Numb n. State)	er or Rural I	Route Number,
rs eft	ed in	Ser.		January, etc. (apar							
To the Hospital or Attending Physicien: The law requires that the death certifice within 24 hours efter death.	To the Funerei Dir completely filled in	edical	29 Certifier 1 Certifying Phy (Check only 2 Madical Exami	sician: To the best of my kn	owledge, deat	n occurred at the tir	ne, date and place, a	and due to the o	euse(s) and ma	inner es stat	ted.
the H in 24	the F		one)	and manner stated.				1900			
o ti	5 g	1	29b. Signature and title of certifier			29c. Licens	_	2	29d. Date signed		
0	1		1666-1	MD			39813		4/ 8	12	000
16	/		30. Neme and address of person who co		m 23a) (Type,	Print)	ll iligh		0000	-00	005 MD 2181
l			Michael R	***		col us	ex might	more (1451-	well ,	MD 2181,
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2005	Registrar's Sign	ature	No B		,			
	Registr	al .	WLU TO TOO	siane li	1500	Charles .					

			1 - For State (Registrar		partment of Health and Mertificate of Death	ental Hygier	/ 11 15	12525
			Decedent's Name (First, Middle, Last)			2. Oate of Death		3. Time of Death
ı	Physici /Medic		Joseph	R. Voe	lker	April	Day Year ブスの5	205 PM
•	Examir		4a. Facility Name (If not institution, give street and no		4b. City, Town, or Location of Death		4c. County of Deat	h
			Stella Maris @ Merc		Baltimore If Under 1 Year If Under 24 Hrs.	0 D (D):1	n/a	
	Funeral Director		5. Social Security Number 219-28-3159 6. Sex	7. Age (In yrs. last birthday 71 Yrs.		8. Date of Birth (Month, Day, Ye, Oct 7, 193	ar) Co	hplace (State or Foreign untry) Yland
			Usual Residence of Decedent			5007,175	/5 IIaI	yrand
	nylan show	_	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
S	Ba-1 s	ecto	Md. n/a	Ва	1timore			1 D∛yes 2 □ No
1	a or 2	Funerai Director	10e. Street and Number 1914 E. Pratt Stree	at	10f. Zip Code 21231	10g.	Citizen of What Co USA	untry?
1	Jeath ms 23	era	11. Marital Status 12. Was Dec			cify Yes or No-	14. Race - Ame	rican Indian,
9	or Itar	Fun	Armed F	2 🗆 No	Was Decedent of Hispanic Origin? (Spelif Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	e, etc.
9	ural', c	d by	3 ☐ Widowed 4 ☐ Divorced If Year or I	Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Itams 23a or 28a-f show int, Its Madical Exercit ett state per retified at	Completed by	15. Decedent's Education (Specify only highest grade completed	16a. Dec	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	g 16b.	. Kind of Business/	Industry
12	withii iene. than	dwc	Elementary/Secondary (0-12) College	1-40r 5+)	ntracting		Construc	tion
Ď	e filed Il Hyg other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name			<u>C1011</u>
<u> ar</u>	should be filed within 72 hours after death with the Marylan Ind Mental Hygiene. Indexed other then "natural", or items 23a or 28a-1 show matic event, it is Marical Ext. if etc. ast be truffled at	To E	John B. Voelker		Helen N	Mary Le	Boyers	
Maryland	is a		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Rural			
	1 and 1ealth 8m 27 ther to		Lorraine G. Voelker,	wife 191	4 E. Pratt St. E	Baltimor	e, Md.	21231
20	Pages nent of I int: If ite		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from	Cernetery, cre	w Crematory 4/9/			
Baltimore,	permit. Pages Department of Important: If it any injury or o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		2. Name and Address of Facility ACZ			
eg —	Depril Impo		rabot & Social		201 Dundalk Ave.	Baltim	ore, Md	. 21222
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.		respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		re ince			Onset and Death
	/Medical Examiner		Due to	(or as a consequence of):				
b	· .	er	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of):				
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
Š	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to	(or as a consequence of):				
2/6U		dical	d					
٥ ک	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23c. If yes, ou	tcome of pregnancy			00d Date of date	
X Q Q	death e atten id for u	cian	in the past 12 months?	birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deli- Month	Day Year
j.	t the c by the achec	hysi	9 ☐ Unknown 9 ☐ Unkr	own				
ω, T	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contributing to c	eath but not resulting in the o	inderlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
ecords,	equire sen si ould b					1 Tes	2 No 3 Pro	babiy 4 Unknown
ပ္	as as as	ompleted				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	Th ate pag	Con				performed?		2□ No
VII	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? Hospital:		26. Place of Death			1
	Phys or this oral di	-	1 163 2 10	Inpatient 2 ER/Outpatie of Injury oth, Day Year) 28b. Time of Injury	1 3 DOA 4 Nursing Hom	e 5 🗌 Residence 3d. Describe how inj		16) hospice
DIVISION	Attending F ir death. actor: After by the funer.	ertification:	1 €Natural 5 ☐ Pending (Mor. 2 ☐ Accident investigation	ith, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		,	
<u> </u>	r Atte er de racto by th	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place build	e of Injury - At home, farm, st ing, etc. (Specify)	reet, factory, office	If. Location (Street a		ral Route Number,
5	ital o irs aft ral Di led in	O						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the b	e best of my knowledge, deal pasis of examination and/or in the stated.	th occurred at the time, date and place, an exestigation, in my opinion, death occurred	id due to the cause(f at the time, date a	s) and manner as and place, and due f	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month,	
	1		· Jul my		D40854		4/8/5	005
3	Mil		30. Name and address of person who completed cause	se of death (Item 23a) (Type,		1. 212	4) =	
	Sta	e		Registrar's Signature		4 (10	<u> </u>	
*	Registr	ar	APR 1 3 2005	More & A	ark			

		ı.	- FOR	epartment of Health and M Certificate of Death		ene g. No: 005	12526
	9		Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physici		Joseph V. Wright, II		Month April	Day Year 7 2005	8:04 a. M
5	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Memorial Hospital	Cumberland		Allega	.ny
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Davs Hours Min.	8. Date of Birth (Month, Day,	Yeer) Co	hplace (State or Foreign untry)
	Director		236-50-0723 - 69	rs.	April 10),1935 Wes	t Virginia
	and		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town	or Location			10d. Inside City Limits
	/anyis	ō	WV Mineral K	eyser			1 ∑Yes 2 □ No
	28e-	ect	10e, Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	with 3e or		646 Carskadon Road	26726		USA	
	death ms 2:	Funeral Director	11 Marital Status 12, Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Ame	
စ	after or Ite	Ē	1 Never Married 2 Married 1 XYes 2 No	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White	e, etc.
8	ral, c	i by	3 □ Widowed 4 ☑ Divorced If Yes, Give Korean Year or Dates: Conflict	1 ☐ Yes 2 No Specify:		Specify: W	hite
21215-0036	72 honatu	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work	ing 1	6b. Kind of Business/	Industry
2	vithin ne. han'	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)	T.	mirroto Torro	
2	iled w tygier her ti		17. Father's Name (First, Middle, Last)	Self employed	e (First, Middle, M	rivate Inv	estigator
anc	be find the	Be					
ž	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23e or 28e-f show Imatic event, I'm Modical Exertine I must be intilling at	ဌ	Joseph V. Wright 19a. Informant's Name/Relationship (Type, Print) 19b.	Virgini Wailing Address (Street and Number or Rur		ine Parson	
Maryland	d2s than t7 is		Joan F. Wright/Wife	646 Carskadon Road			
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-1 show eny injury or other treumatic event, If a Medical Eventral terminal termination.		20a Method of Disposition 20b. Place of I	Disposition (Name of	Date 2	0c. Location - City or	
altimore,	Pages nent of H ent: If ite ury or of		1 Burial 2 X Cremation 3 Hemoval from State		il 11	Cumberlan	4 MD
Ē	nit. F artmo orter injur		21. Signature of Funeral Service Licensee		005 Lith Fune:		d, m
ä	permit. Departr Importe eny inji		Baran Forth	85 S. Main Street			726
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Severe Cardiomy	onathy			Onset and Death 5 years
	/Medical		resulting in death) Due to (or as a consequence of				5 years
и	Examiner		Sequentially list conditions b. Coronary Artery	Disease			5 years
	ם ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury):			
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)-			
8760,	be ex cian burial	al E	24 5 7 7 25 25 25 25 25 25 25 25 25 25 25 25 25	<i>y</i> •		j	
387	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	d				
9 x	eath certific attending p	//Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	3.00		23d. Date of deli	verv
Вох	atter for L	clar	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
0	that the death	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
ص.	es that igned t be det	by P	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rd	w require been sig should b	edt	End Stage Renal Disease		1 ☐ Yes	s 2□No 3□Pro	obably 4 🕅 Unknown
000	e law requ has been je 2 shouli	Completed			24a. Was an autopsy		topsy findings available completion of cause of
ž	The ate he	E O			perform	ed? death?	2 No
ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)	
× ×	Physic this ca	2	1 ☐ Yes 2 💢 No Hospital: 1 💢 Inpatient 2 ☐ ER/Out	The second secon		nce 6 ☐Other (Spec	pify)
n o	ding P. h. After I	ion:	A Natural S I briding	ury Work?	28d. Describe hov	v injury occurred	
Sic	Attending r death. sctor: Afte	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fam	M 1 Tyes 2 No	28f Location (Stre	eet and Number or Ru	ral Route Number
Division of Vital Records,	l or Atteno after deatl Director:	Certification:	4 Homicide determined building, etc. (Specify)	n, street, ractory, office	City or Town,		rai i roote i variber,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1X Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place.	and due to the cau	use(s) and manner as	stated.
	e Ho 24 h e Fui letely	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and and manner stated.	or investigation, in my opinion, death occuri	red at the time, dat	te and place, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	n, Day, Year)
•	./		NAKMIS (MB)	D19318		April 11,	2005
ĺ	11		30. Name and address of person who completed eause of death (Item 23a) (T	ype, Print)			
1	1		N.A. Ranjithan, M.D. 517 Oldto		, MD 215	502	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2005	de			
	, legisti	4	WILL TA CAAA MONTHER				

Gary Winslow 05-02474 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

)	/4		For Unper 1 - State Registrar	nd Item	238 tate of	Maryla 8a-1	and/Dep per me <i>Ce</i>	artmen G842 rtificate	1.º15 e of l	ealth a 05 t Death	and M	ental Hy	giene Reg. No.	00	5 12	5 2	27
	Dharaisi		1. Decedent's Name	(First, Middle,	Last)							2. Date of De	eath Day	,	3. T	ime of D	eath
	Physici /Medio		Gary		M	auri	ce	,	Win	slow	J	April	7	005		47 F) M
	Examir		4a. Facility Name (If	not institution,	give street and num	nber)		4b. City,	Town, or	Location	of Death		4c.	County of	Death		
V			Franklin	Square	Hospital				eda1					altin			
3	Funeral		5. Social Security Nu	mber	6. Sex 1 M 2 ☐ F		rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 3 0	rth av, Year)	6	9. Birthplace (5 Country) MD	State or I	=oreign
7	Director		214-64-6 Usual Residence of I	0485		49) 11s.					03	5 5	0	נוט		
4-3	and and			10b. County		10c.	City, Town or L	ocation			-				10d. Ins	ide City	Limits
	Mary f sho	jo	MD	NA		I	Baltime	ore							M	XYes 2	! □ No
	28a	Director	10e. Street and Num	ber				10f. Zip	Code				10g. Citi	zen of Wh	nat Country?	-	
	3a or	0	6130 Ma	ranatt	e Road	Ant 1	r.		212	06				U.S	5.A.		
	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examiner must be rodified at	by Funeral	11. Marital Status	<u>Lque</u> c	12. Was Dece	dent Ever in	1 U.S. 13.	Was Deced			igin? (Spe	cify Yes or No Rican, etc.)	0-		- American Ind White, etc.	an,	
ဖွ	after or ite	E.	1 Never Marrie	d 2💢 Marrie	d 1 ☐ Yes If Yes, Give	2XIZXNo		1 ☐ Yes y		Specify:		iloan, etc.)	1	Specify:			
93	ours	d b	3 Widowed 4	Divorced	Year or Da	ites:									Blac	K.	
5-(72 h natu	Completed	(Specit	15. Decedent's only highest	s Education grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa nk done d	ation during mos	st of workin	ıg	16b. Ki	nd of Busi	iness/Industry		
2	vithin ne. han	mp	Elementary/Secon		College (1-	-4or 5+)		ruck		_			T F 13	okir	ng Com	nan	3.7
2	filed within Hygiene. Ither than ont, the Mar	ပိ	11th gra		na			I L UCK	DE		er's Name	(First, Middle				pan	<u>y</u>
anc	ntal hed of	Be											11111				
Ž	2 should be filed withir and Mental Hygiene. is marked other than surmatic evant, the M	^L	Otis Wil		in (Type Print)		19h Maili	na Address	(Street a			Ransor		Town, S	tate, Zip Code)		
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examiner must be notified at		Yvonne						•						Lto, M		120
Ġ	1 an Heal sam 2		20a. Method of Dispo		JW-WITE	201	p. Place of Disp	sition (Nan	ne of	I		ate			ity or Town, St		
õ	ages nt of t: If it		1 Starial 2	Cremation	3 Removal from S		cemetery, cre			- 1	4/1/	5 /OE	D = 10	٦ ـ ١ ٦	~+~~~	M	a
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai		4 Donation		* *	OK.	ing Me	MOĽ16 2. Name an				3/03	Kan	dall	stown	, 14	a
Ba	Depa Depa Impo any I			BIL			M	arch	F/H	Wes	st					215	
			23a. Part1. Enter the	e disease, or o	complications that ca	aused the de						Balt:		e, r	Appro	215 ximate	
			shock, or heart Immediate Cause (F	t failure. List o	inly one cause on ea	ach line.									Onse	al Betwe and De	ath
	Physician / /Medical		disease or condition resulting in death)		a		ne Into: sequence of):	xıcatı	LON						-		
	Examiner				Due to (t	or as a corrs	sequence or,										
		ē	Sequentially list con if any, leading to impact cause. Enter Under Cause (Disease or in	ditions, nediate	b. Due to (c	or as a cons	sequence of):										
	ate be executed by sician and the burial-transit	Examiner	Cause (Disease or in that initiated events	lying njury													
Ć.	exec in an	Еха	resulting in death) La	ast	Due to (c	or as a cons	sequence of):										
760,	e be /slcia e bur	cal			d												
89	Attending Physician: The law requires that the death certificate be executed rideath. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit																
Вох	eath certific attending pl for use as t	Physician/Med	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outo	come of pre		∃Ectopic pr	ean ancy				2		of delivery		
	that the death cer ed by the attendir detached for use	cla	in the past 12 r 1 \square Yes 2 \square			ant at time o		Other (sp						Monti	h Day	Ye.	ar
P.O.	it the d by the tached	hys	9 🗆 Unknown		9LJ ONKNO	WII											
	iw requires that s been signed k s should be det	by F	Part II. Other signific	cant condition	ns contributing to de	ath but not	resulting in the u	inderlying ca	ause give	en in Part I	l.	23e. Did			ute to the caus	2	
p	en si	ed										1 🗆	Yes 2	∐No 3	Probably	4 Uni	known
သွ	e law re has be	Completed										24a. Was		24b. We	ere autopsy fin or to completio	dings av	allable
æ	The ate ha	mo;										1 Yes	ormed?	dea	attr? ZYes 2∐N		
Division of Vital Records,	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Be	25. Was case referre	ed to medical						26. Place	of Death	(Check only	оле)				
>	Physic this ce al direc	70 6	1X Yes 2□N	40	Hospital: 1 ☐ Ir	npatient 2	ER/Outpatie	nt 3 DO	A Othe	er: 4□Nı	ursing Hon	ne 5 🗌 Resi	idence 6	Other			
0	ding Pl	ü	27. Manner of Death 1 □ Natural	5 Pending	28a. Date o Found ^{at}	f Injury h, Day Year	Found	if 2	8c. Injury Work	at </td <td>2</td> <td>8d. Describe</td> <td>how injury</td> <td>occurred</td> <td>t t</td> <td>nk</td> <td></td>	2	8d. Describe	how injury	occurred	t t	nk	
.0	death. ctor: A the fu	Certification:	2 Accident	investig	4-8-05	5	6:34	\mathbf{P}^{M}	1 🗆 ,	Yes 2							
Ξ̈́	l or Attendation of attendation of the order:	ıţţ	3 🗋 Suicide 4 🔲 Homicide	determin	ned 288. Place buildin	of Injury - A ng, etc. <i>(Spe</i>	t home, farm, st ecify)	reet, factory	r, office		2	8f. Location (City or To	Street and wn, State)	6139	or Rural Route	Numbe	Rd.
Ω	To the Hospital or A within 24 hours after To the Funaral Dirac completely filled in by	Ce			Ноте							altimo					
	Hospital 24 hours a Funaral tolk filled	edical	(Check only		Physicien: To the examiner: On the ba	sis of exam										use(s)	
	To tha within 2 To the complet	Med	one) 29b. Signature and t	itle of certifier	and mann	er stated.		290	ticense	number			29d Date	a signed /	Month, Day, Y	ear)	
	7 × ii c		Signature and t	We or cerminal	· D	2			.C.M				Apri	_		/	
	λ		- Yals	سانس	non-18	HUL	~		, O . IY	1.1.			TT.	L 2,	2007		
18	Der		Name and addre	ss of person v	who completed cause	of death (I	tem 23a) (Type,	Print) Penn S	tree	et. R	altim	ore, M	arv1	and 2	21201		
	1		31. Date filed (Month	Day Voor	10010A-	egistrar's Sig						, , , ,					
	Sta Registi	1.0	JI. Date filed (MONII	, vay, rear)	PR 1 3 2	95. ar 3 31	Mar 2-care	12	Som	200							
					7. 0 60	00	artist of the	1900	The state of the s	-							

I			State of Maryland / Department of Health and Maryland / Department of Health / Department / D	1ental Hygi ®	ene 005	12528
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	/Medio		Delia Hanna Young	APRIL		12:50 Рм
	Examir	ner	4a. Facility Name (If not institution, give street and number) ST AGNES HOSPITAL 4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
553	Funeral Director		5. Social Security Number 214-46-9095 6. Sex 1 \square M 2 \square F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sept.]		place <i>(State or Foreign</i> ntry) ary1and
+)	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		- 1	0d. Inside City Limits
	a-f sh	ctor	Maryland N/A Baltimore		_	1 Yes 2 No
	h with the 23a or 28 st be no	al Director	10e. Street and Number 2219 Wilkens Ave. 10f. Zip Code 21223	10	og. Citizen of What Cour	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.	by Funeral	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh:	etc.
21215-0036	within 72 ho ane. than "natur he Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Beautician	ing	6b. Kind of Business/In	dustry
land 2	id be filed ental Hygin ked other ic event, II	To Be Co	17. Father's Name (First, Middle, Last) Thomas M. Thompson 18. Mother's Name Madge Us	e (First, Middle, M		
Maryland	nd 2 shouluith and M 27 is mari	1	19a. Informant's Name/Relationship (Type, Print) Madge Ussery, mother 19b. Mailing Address (Street and Number or Rure 2219 Wilkens Ave. Balt	al Route Number, Cimore, M	City or Town, State, Zip	Code)
Baltimore,	Pages 1 a nent of Hes int: If Item iry or othe		Zod. Wolfred of Diaposition		Oc. Location - City or To Saltimore, A	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Ho 1328 Sulphur Sprin	ome, Inc.	butus. MD.	21227
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxication Due to (or as a consequence of):			Approximate Interval Between Onset and Death
8760,	ficate be executed to physician and strength such a purial-transit and strength such a purial-transit and such as the burial-transit and such as the purial-transit and such as the purial	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease of Figury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
P.O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending frid director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 SEctopic pregnancy 5 Other (specify) 9 Unknown		23d. Date of delive Month	ory Day Year
	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the	ne cause of death? ably 4 DUnknown
of Vital Records,	ysician: The law requi is certificate has been s director, page 2 should	Completed		24a. Was an autopsy perform	prior to cor ed? deat/?	psy findings available npletion of cause of 2 No
Vita	sician: Th certificate rector, pag	Be c	25. Was case referred to medical examiner? X Yes 2 No Hospital: 1 Inpatient 2 FeVOutpatient 3 DOA Other: 4 Nursing Ho			
	Jing After fune	tion; To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 OO DM 1 To See 2 M No.	me 5 ☐ Residen 28d. Describe how	ce 6 □Other (Specify v injury occurred t	nk
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town, Baltimore	eet and Number of Russ State) 2219 Wil e, Md	Route Number, kens Ave.
	To the Hospital within 24 hours and the Funeral completely filled		29a. Certifier (Check only 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)	and due to the cau	use(s) and manner as st e and place, and due to	ated. the cause(s)
	thin 2 the I the I	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		d. Date signed (Month, I	
	Tw. v		Mouhite melskill m OCME		PRIL 10, 20	,
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANY CORD 1111 PENN STREET,	BALTIMOR	E, MARYLANI	, 21201
2	Sta Registr	1.6	31. Date filed (Month, Day, Year) APR 1 3 2005 Registrary Signature			

			For State Registrar	State of Maryla		artment of F		d Mental Hy	/giene	05	12529
			Decedent's Name (First, Middle, Last)				-	2. Date of D	eath		3. Time of Death
	Physici		Sherman Robert	Lee Armstea	ad			Month	27, 20)05	16:00p ^M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of De	eath		ty of Death	
ı			Shady Grove Adven	tist Hospita	1	Gaither	sburg		Montg	gomery	7
	Funeral		Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 H	in. (Month, D	av. Year)	Cou	place (State or Foreign
L	Director		226- 44-1623	M 2□F 69	Yrs.			June 1	18, 1935	Virg	inia
	pug *		Usual Residence of Decedent 10a, State 10b, County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	sho	5									1 Yes 2 □ No
	28a-1	ect	Maryland Prince Geo	orge Di	strict	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	with Sa or	<u></u>	1207 Addison Road	#34		20743			United	State	s
	within 72 hours after death with the Maryland ane. then "netural", or Itema 23a or 28a-f ahow he Madigal Examiner must be multind at	Funerai Directo		12. Was Decedent Ever in	1 U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or N		ace - Ameri	can Indian,
ယ	or Item	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	- 1	If Yes, specify Cub:		erto Hican, etc.)		ack, White,	
Ö	ral', c	ξ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		TES ZALINO	Specify:		Spec	ity: Blac	CK
21215-0036	72 ho natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	during most of v	vorking	16b. Kind of	Business/In	dustry
7	Man Man	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)				
7	led w lygier her ti		11th 17. Father's Name (First, Middle, Last)		Engi	neer	19 Mother's h	lame (First, Middle	1	vate	
and	be fi	Be	Robert Lee Armste	nd						anne)	
Maryland	d Mer narke	۴	19a. Informant's Name/Relationship (Typ		10h Maili	ng Address (Street		sabelle V		n State 7	Codo)
Ma	12 st h and 7 ts n traun			Wife		Executive			•		· ·
o,	1 and Healt em 2		20a. Method of Disposition			sition (Name of matory or other place		Date Date	20c. Location		
ğ	nt of nt of t: If it		1 ☐ Burial 2 ☐ Cremation 3 🕅 R			matory or other pla eral Home		4 05	Chamles		1110 000
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Itema 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be recitified at ODGe.	1	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Icicense 						1	LLESV.	ille, Va.
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	Physician		23a. Part 1. Enter the disease, or complishock, heart failure. List only on Immediate Cause (Final			ter the mode of dyir			arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons		CEMAI	1417	176			· wax
	Examiner		Sequentially list conditions,		PSis						1 week
	pe jis	iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as a cons	requence of):	146					I week
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons		119					1 404/6
8760,	be e) ician buria										
687	phys phys s the	dic	0		-						
Box (death certific e attending pl id for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre-					23d. E	ate of deliv	ery
ă	Jeath atter	ciar	in the past 12 months?	1□Live birth 2□F 4□Pregnant at time of		□Ectopic pregnanc: □ Other (specify) _	y		N	Month	Day Year
0	the che	hysi	9 Unknown	9□ Unknown	-			-			
<u>0</u>	es that igned b	by P	Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
Ď	w require been sig should b	edt						_ 1 🗆	Yes 2 No	3 Pro	bably 4 Dunknown
ပ္သ	The law requires ite has been sign age 2 should be	Completed						24a. Wa		. Were auto	opsy findings available impletion of cause of
æ	The lay	E						peri 1 ☐ Yes	ormed?	death?	
Vital Records,	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?				26. Place of C	Death (Check only	one)		
of <	S 5	으	1 Yes 2 No		P ☐ ER/Outpatie		4 🔲 Nursing	g Home 5□Res			fy)
0			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	₩o	rk?	28d. Describe	how injury occ	urred	
sio	Attending r death.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No	00/ 1	/// · · · · · · · · · · · · · · · · · ·	, .	10
Division	e e e e e e e e e e e e e e e e e e e	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	it home, farm, st ecify)	reet, factory, office		City or To	(Street and Nur Dwn, State)	nber or Hur	al Route Number,
	pltal burs seral filled			sician: To the best of my							
	To the Hos within 24 h To the Fur completely	ledicai	one)	ner: On the basis of exam and manner stated.	ination and/or in			ccurred at the time			
	Vith Con	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date sign		*
	0		1 a		Δ	0.2	667 5		much	29,	5002
		1	30. Name and address of person who co	impleted cause of death (I	tem 23a) (Type,	Print)					
	(6)		44. 14 4 66	A H A	0001	MA - 11.	1 1-1	A .	1 . 1	. 7.	A 2 NECO
	Sta		Matthew Poff 31. Date filed (Month, Day, Year)	encets, MD	990 l	D5 Melica	Cenh	- Drive,	Lock	114 A	11 20850

		For Stete Registrer	State of Ma	ryland / D)epa		t of H	ealth a					10500
-3		1. Decedent's Name (First, Middle, Last) 2. Date of Death										3. Time of Death	
Physic /Medi		Paul A. Ashby								Day	Year OS	- 22:30 M	
Exami											4c. County of Death		
		SACRED HEART					SMO	SERL	-AN	D		LLEG	ANY
Funeral Director		212-24-1024	x 7. Age	(In yrs. last bir	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 4/15/	29 (1902)	9. Birt	hplace (State or Foreign untry) Ledmont , WV
and		Usual Residence of Decedent 10a. State 10b. County	T	10c. City, Towr	or Lo	cation							10d. Inside City Limits
Maryl f sho	ō	MD Allegan	y	Weste	rn	port							1 ☐ Yes 2X No
with the Jacor 28a-	i Direct	10e. Street and Number 25701 Shady Lan	e			10f. Zip	Code 2156	52-20	017		10g. Citizer	of What Co	untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be inclifted at ance.	y Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 3 □ No Specify:							Race - Ame Black, White				
21215-0036 solution 72 hours aft giene. arthan "naturel", or the Madical Exami	d by	XXWidowed 4 □ Divorced	Year or Dates:	Korear	1								
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withi thene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	_	orem					Con	struc	ction
Maryland 2 nd 2 should be filed lth and Mental Hyg 27 is marked other treumatic event,	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, N						Maiden Su	faiden Sumame)				
shou mar	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b.	Mailin	g Address	(Street a	nd Numbe	r or Rura	Route Number, City or Town, State, Zip Code)			
Md 2 alth a alth a 27 is		Joan Stickley/s	sister		3	15 H	i111	top i	Ave.	, Key	ser,	WV 26	5726
of He Itam		20a. Method of Disposition		20b. Place of cemeter	Disnos		ne of			ate		ion - City or	
Page Page nent c		1 ☐ Burial ŽŽCremation 3 ☐ F		Scarp					4/08/	/05	Cresa	ptown,	, MD
Baltimore, permit. Pages 1 a Department of Hec Important: if Itam any injury or otha		21. Signature of Funeral Service Licens	Nofre		1	Name and Markw	boor	Funer	al E	Home, In ser, WV	nc. 26726	;	
Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									Approximate Interval Between Onset and Death		
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COTGS, P w requires that been signed t should be det	þ	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the un	derlying ca	ause give	n in Part I. Facili	urs		obacco use 'es 2 🗆 N		the cause of death?
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hysic hysic his ce	P	1 ☐ Yes 27 No		nt 2□ER/Out				4 🗆 1401	rsing Hon	ne 5□Resid	lence 6	Other (Spec	sify)
Jing Afte fune	tion:								now injury or	njury occurred			
Division of a or attending Phy after death. Diractor: After this din by the funeral d	Certification;									umber or Ru	ral Route Number,		
Division To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exemi	sicien: To the best o ner: On the basis of and manner stat	examination and	, death Vor inv	occurred a estigation,	at the time in my op	e, date and inion, deat	place, a	and due to the	cause(s) and date and pla	d manner as	stated. to the cause(s)
roth Mithin Foth:	Me	29b. Signature and title of certifier				29c.	. License	number			29d. Date si	igned (Month	, Day, Year)
. , , ,) de	\int				c G	124	4		11	101.	2005
1		30. Name and address of person who or DR. JESUS TAN	Route	ath (Item 23a) (Type, F					32		/ 0 / -	
Str	ate	31. Date filed (Month, Day, Year)	32_Registra		0.5	- ~ .	21.						
Regist		APR 1 3 200		. K	dos	200							

			1 - For Stete Registrar	State	of Maryla		artment of Hertificate of L		nd Mental Hy	giene Reg. No.	005	12	531	
			Decedent's Name (First, Middle, Last		2. Date of De									
	Physici		FLORA VIRGINIA		Month Marci			Year 2005	7.47	Рм				
	/Medio Examir		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of E			ity of Death	7.4/		
			300 Woodlawn Ave	nue			Delmai	r		Wic	omico			
	Funeral		5. Social Security Number 6. S	эх	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8 Date of Bir Min. (Month, Da	th		ace (State of	or Foreign	
	Director		144-26-7783	□M 2131F	94	Yrs.			July 1,	1910	Mary			
	p z		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	cation				10	Dd. Inside C	ity Limits	
	sho	č			1,555	•							2 🔯 No	
	the N	Director	Maryland Wicomico			Delm	10f. Zip Code			10g. Citizen o	f What Coun	trv2		
	with		300 Woodlawn Av	enne			21875			USA	. Trinat Oddin			
	eath	Funeral	11. Marital Status		edent Ever in l	J.S. 13. \		panic Origin	? (Specify Yes or No		ace - America	an Indian,		
	fier d	臣	1 Never Married 2 Married	Armed F 1 ☐ Yes	orces? 2 📉 No	'	f Yes, specify Cuban	i, Mexican, F	Puerto Rican, etc.)	В	lack, White, e			
ğ	urs a	þ	3X Widowed 4 ☐ Divorced	If Yes, G Year or E	ive Dates:		1 ☐ Yes 2X No	Specify:		Spec	^{ify:} Blacl	ζ		
ဝှ	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. do there then "natural", or items 23e or 28e-f show event, the Madral Examinating rount to motified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working						f working	16b. Kind of	Business/Ind	ustry		
2	thin e	nple	Elementary/Secondary (0-12) College (1-4or 5+)							_				
2	Hygier Hygier Sther th	ပ္ပ	8th			Stock					tment	Store		
Maryland 21215-0036	be fil htal H d off	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	, Maiden Sumi	ame)			
3	should be f and Mental I is marked of sumatic eve	၉	Emory		Go	ordy			Rosa			lby		
<u>a</u>	12 sho h and 7 is ma	4 4	19a. Informant's Name/Relationship (7			2	•		or Rural Route Numb			Sode)		
e)	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	- 13	Marion Handy/niece	;	20b.	Place of Dispo	sition (Name of		Delmar.	MD 218 20c. Location		wn. State		
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altimore,	iit. Partme artme orteni injury	1	* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		lun	ion U.M	Name and Address	GE (U4) s of Facility	/02/2005 1213 Jerse	Delma	r, Mar	yland	MD	
Ba	permit. Pages 1 and Department of Healt Importent: if item 2 any injury or other 20028.		HILTERAL	16	11011					y Koau	- Sai.	218 218		
			23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate										te	
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o	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr		3 C	Curer (apecity)							
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ပ ္ပ	w require been sign should b	Completed							24a. Was		. Were autop	sy findings	available	
He	he lav e has age 2	mo		-						rmed?	prior to com death?		ause of	
		a	25. Was case referred to medical					26. Place of	Death (Check only o	1 Yes 2 No 1 Yes 2 No				
	ysici is cer direc	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	t 3 DOA Other	4 ☐ Nursii	rsing Home 5 PResidence 6 Other (Specify)					
0	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date (Mor	of Injury hth, Day Year)	28b. Time of Injury	28c. Injury	at ?	28d. Describe I	28d. Describe how injury occurred				
<u> </u>	Attendir death. ctor: Al y the fu	atk	2 ☐ Accident investigation				M 1 🗆 Y							
Division of	or Attending Physician: Ifter death. Director: After this certific. in by the funeral director,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	286. Place	e of Injury - At h ling, etc. <i>(Speci</i>	ome, farm, stre fy)	eet, factory, office		28f. Location (S City or Tov	Street and Nun vn, State)	nber or Rural	Route Num	ber,	
	pital ours a seai D		20 0 15 15 15 15 Ph				1 . 11 . 12							
	Hos 24 ho Fun Fun	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 0ne) 2 ☐ Medical Exam	iner: On the b	e best of my kn basis of examin: nner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my opi	e, date and p nion, death o	place, and due to the occurred at the time,	cause(s) and r date and place	nanner as sta , and due to	ted. the cause(s	;)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier	und mar			29c. License	number		29d. Date sign	ed (Month, D	lay, Year)		
•	100		> Wemby	_			Doc	1359		Monch	314	2000	-	
	g,		30. Name and addr *** of person who	ompleted cau	se of death (Ite	m 23a) (Type, I	Print)	1337		100100		2003	-	
	0		DR-USHA	NATE	SAN	141	5-S-DIVI	SION	ST SAC	SBURY	ON	2/80	4	
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	Registr	ar	0 1			1								

			1 - For State Registrar	State of	Marylaı		artmer <i>rtifica</i> :					Reg. No	2005	253	33
			1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	eath Da	y Year	3. Time of Dea	ith
	Physici /Medio		LARRY	В	RINKI	EY					March	26	, 2005	2:30A	М
	Examir		4a. Facility Name (If not institution	, give street and numb	er)					of Death		40	. County of Death	1	
			Civista	Medical	Cente	er	J	LaP1	ata				Charle:	S	
	Funeral Director		5. Social Security Number 577-74-8083 Usual Residence of Decedent	6. Sex 7. X □ M 2□ F	Age (In yrs.	. last birthday) Yrs.		Days	If Unde Hours	Min.	8. Date of Bi (Month, Di Septembe	rth ay, Year, 23,	9. Birth Co. 1954 Was	place (State or For intry) nington, D	reign
	and w		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Lir	mits
	Many	ō	DC.		Was	hingt	on							1 X Yes 2 □]No
	188-	Je C	10e. Street and Number		i		10f. Zi	Code				10g. Ci	tizen of What Cou	intry?	
	Sa S	0	726 Crittend	len St. Ni	Ξ.			200	17			J	IS A		
	Heath The 2	Funeral Director	11. Maritai Status	12. Was Decede	ent Ever in U	J.S. 13.	Was Dece			rigin? (Sp	ecify Yes or No Rican, etc.)	o- T	14. Race - Amer	ican Indian,	
10	riter	표	1 ☐ Never Married 2 💢 Marr	Armed Force	es? €⊓No						Rican, etc.)		Black, White		
93	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1 🗆 Yes	2LANO	Specif	y:			Specify: D1	ack	
9	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Exandrat intest be notified at	Completed	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usu	al Occup	ation	at of work	in a	16b. K	ind of Business/I	ndustry	
215	hin 7	pie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT L	se retired	during mo	st of work	ing		Private		
7	filed within Hygiene. other than "	00	12th			Pr	inte	er						= 	
3 1	al Hy al Hy ofth	Be (17. Father's Name (First, Middle,	-							e (First, Middle	, Maiden	Sumame)		
콜	should be nd Mental marked c	2	William	H. Brin	ıkley				Do	roth	У		J	ones	
Brinkley Maryland 21215-0036	2 sho and is ma		19a. Informant's Name/Relations	nip (Type, Print)									or Town, State, Zi		
	and salth		Sherry Brink	rey, wire	<u> </u>	1408	t'11In	ore	Rd.	Ft. W	ashing	ton,	MD. 207	44	
`. ore	of He		20a. Method of Disposition 1 Denial 2 Cremation	2 DRamoval from St	20b.	Place of Dispo cemetery, crei Linco	sition (Na matory or o	me of other plac	ce)	04/0) /05	20c. Lo	ocation - City or T Ltwood, M	own, State	
arry Itimor	Pag nent ant: I		' 4 □ Donation 5 □ Other (S)	pecify)	FC.	Linco	oin Ce	emete	ery	-, 0	., 03	DICI	ewood, 1	.	
Larry Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Exameras mast be notified at once.		21. Sgn a tre of Funeral Service	Les Pal	tush		2. Name ai ianchi				St. NW V	wash.	DC. 2001	1	
			23a. Part1 Enter the disease, or shock or heart failure. List	complications that cau	sed the dea	th. Do not ent	er the mod	de of dyin	g, such a	s cardiac o	or respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final											Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or	as a consec	nonic	1								
	Examiner			7		nia									
		Je.	Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury	Dua to (òr		uence of):									
	be executed sician and burlal-transit	Examiner	Cause (Disease or injury that initiated events	c .											
o,	exectan an arrial-t		resulting in death) Last	Due to (or	as a consec	quence of):									
8760,	ate be hysicii the bu	cai	y .	d											
9	tifica ng ph as th	Med		1											_
Box	eath certific attending pl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic p	eanancy					23d. Date of deliv		
	deat	icle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan 9□Unknow	t at time of c		Other (sp						Month	Day Year	
P.0	that the de	hys	9 Unknown	9 Onknow											
Ś	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by F	Part II. Other significant condition	ns contributing to deat	h but not res	sulting in the ur	nderlying o	ause give	en in Part	I.	23e. Did t	obacco u	ise contribute to t	he cause of death?	?
Ď	w require been si	ed	Chroni	c Liver	dis	-lase					10	Yes 2	□No 3□Prol	oably 4 Onkno	nwc
ပ္ထ	aw respectively	Completed									24a. Was		24b. Were auto	ppsy findings availa	able
æ	sician: The law certificate has E lirector, page 2 s	E										ormed?	death?		OI.
ta		Be	25. Was case referred to medical						26. Plac	e of Death	(Check only o				
>	ysic is ce direc	ToE	examiner?	Hospital: 1 Inp	atient 2	ER/Outpatien	t 3 🗆 DO	Othe	er: 4□N	ursing Hor	ne 5 Resid	dence	6 □Other (Specia	(y)	
0	ng Ph ter th		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of I (Month,	njury Dav Year)	28b. Time of	2	8c. Injury Work			28d. Describe I				
<u>.i.</u>	Attending Physician: r death. ector: After this certific: by the funeral director.	atic	2 Accident investig	ation	,	,,	М		Yes 2]No					
Division of Vital Records,	i or Attendater deati	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		Injury - At hetc. (Specif	ome, farm, stre	eet, factor	, office		2	28f. Location (3 City or Tox	Street an	d Number or Rura	al Route Number,	
	Ital or A	Ser		1									, 		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the be examiner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred estigation	at the tim , in my op	ne, date a pinion, de	nd place, a ath occurre	and due to the ed at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		1		290	. License	number			29d. Dat	e signed (Month,	Day, Year)	
				~ \	SUC	K		D-00	0604	56		3	127/0	5	
_ ^	(2)		30. Name and address of person v												
CH	6		Dauod Ghafa				ooke	Sq	Ste	104	Wald	orf,	MD 20	603	
	Sta Registra	0	31. Date filed (Month, Day, Year) MAR 3 0 20	05 See 2. Regi	strar's Signa	Serve	2								

			1- State of Maryland / Departs Registrar Certif	ment of Health and M	, ,	ene 005	12531					
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death					
	/Media	al	Clementine H. Barnes 4a. Facility Name (If not institution, give street and number) 4b.	MARCH	28, 2005 4c. County of Death	4:38 PM						
	Examir	er	Doctors Community Hospital	b. City, Town, or Location of Death Lanham		Prince Geo	orges					
	Funeral Director			f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	ear) Count	ace (State or Foreign ry) ord, NC						
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	ion		10	d. Inside City Limits					
:	Maryl s-f sho	tor	MD Prince Georges Hyattsvill	le			1√1 Yes 2 □ No					
	or 28	Direc	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Count	ry?					
	s 23a	rall	829 Fairoaks Avenue	20783	7 1/ 1/	USA						
036 urs after dez	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-1 show any njury or other treumatic event. Ite Modical Examinar must be notified at ODGs.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	s Decedent of Hispanic Origin? (Spe as, specify Cuban, Mexican, Puerto f Yes 2 No Specify:	city Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Black	tc.					
21215-0036	"natur	letec	(Specify only highest grade completed) (Give kind	t's Usual Occupation d of work done during most of workin NOT use retired)	ng 16	b. Kind of Business/Indo	ustry					
212	d withii jiene. ir then	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	tician	5	Self Employe	ed					
pu	be file ital Hy id othe		17. Father's Name (First, Middle, Last)	18. Mother's Name		iden Sumame)						
Maryland	should nd Mer marke matic	은	Andy Williams Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Mo11y V		ity or Town. State. Zip (Code)					
Ma	alth ar			Jenkins Ridge Rd.		*	,					
Baltimore,	ges 1 of He If item or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	ory or other place)		c. Location - City or Tow						
	nit. Pa artmen ortant: njury		Arlington NAtional Cem 4-12-05 Arlington, VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MArshall's Funeral Home									
å	Den Imp p		1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7 9th. St. N.W. V								
	Physician		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a PESP(RATORY, FA) URE Approximate Interval Between onset and Death onset and Death onset and Death onset and Death of the Cause (Final disease or condition)									
	/Medical Examiner		resulting in death) Due to (or as a consequence of): P ~ E									
	₽ ≃	ner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying				7					
	ficate be executed g physician and ts the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):									
8760,	e be e /sician e buria	dlcal E	d									
9	artificat ing phy e as th	Medi	IF FEMALE:									
P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	opic pregnancy her (specify)		23d. Date of delivery Month D	y Day Year					
rds, P	w requires that the de been signed by the a should be detached f	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	co use contribute to the cause of death? 2 No 3 Probably 4 Conknown								
Vital Records,	The law requate has been bage 2 should			24a. Was an autopsy performed 1 □ yes 2 2 2								
/ita	contifications	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No Hospital: ☐ Hospital: ☐ ER/Outpatient 3	26. Place of Death	(Check only one)							
Division of Vital Re to the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ding Physin. h. After this of	tlon: To	e 6 □Other (Specify) injury occurred									
	s after dea s after dea el Director ed in by the	Certification:	Accident investigation M 1 Yes 2 No 3 Suicide 4 Homicide 4 H									
	the Hospl in 24 hour the Funer pletely fill	Medical ((Check only one) 2 Medical Exeminer: On the basis of examination and/or investionel and manner stated.	igation, in my opinion, death occurred	t the time, date and place, and due to the cause(s) and manner as stated. in my opinion, death occurred at the time, date and place, and due to the cause(s)							
,	with To I	2	29b. Signature and title of certifier	29c. License number D-3 4 5 2	29d.	Date signed (Month, Da	ay, Year)					
C	(10) Sta	to.	30. Name and address of person who completed cause of death (Item 23a) (Noe. Print 23a) (No	sylve race	P; #2	-20, Bor	20716					
	Registr		31. Date filed (Month, Day, Year) MAR 3 0 2005	,								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:30 AM 24,2005 MARCH CURTIS WILLIAM BRODEN SR. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner GENESIS HEALTHCARE LAYHILL CENTER SILVER SPRING

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | HUnder 1 Year | HUnder 24 Hrs. 8. Date MONTGOMERY Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1₩ 2□F 70 3,1934WASHINGTON DO Director 578-44-7336 Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "naturel", or Items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No Silver Spring Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20906 3227 BelPre Road death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Its marked other than "naturel", or Ite sther traumatic event, the Modest Examina 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify If Yes, Give Year or Dates: 1952 Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. J other than " Elementary/Secondary (0-12) College (1-4or 5+) U.S. Gov't. <u>Insurance Examiner</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Felder Henry William Broden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health as Important: If item 27 is eny injury or other trav 2819 Citrus Lane,Springdale, MD 20774 Gary E. Broden/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Lincoln Mem. Cemetery3/28/2005 Suitland, MD 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Funeral Service Licenses land 4111 Pennsylvania Ave., Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Encephalopathy /Medical Due to (or as a consequence of) Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Hypertension Due to (or as a consequence of) attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Prostate Cancer 1 Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Inpatient Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No P 2 ER/Outpatient 3 DOA this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No reral Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated within 24 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D56691 mousia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ghousia Sultana, M.D. 12107 Heritage Park Circle, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) State MAR 2 9 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:05AM M MARIA-THEREZA BECKSTEAD MARCH 28 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CAMBRIDGE DORCHESTER MALLARD BAY NURSING CARE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 10 1922 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K F Months Days Hours BRAZIL Yrs 82 077-42-6552 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County s 23a or 28a-f show Y∏Yes 2 No Director MD DORCHESTER CAMBRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 GLENBURN AVE. 21613 BRAZIL Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner re-Pages 1 and 2 should ba filed within 72 hours after or theatth and Mental Hygiene. 1 Never Married 2 Married X Yes 2□ No Specify: PORTUGUESE Baltimore, Maryland 21215-0036 ō Specify: WHITE 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FOREIGN GOVERNMENT 12 TRANSLATOR othar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be markad REUBEN MOITINHO JUDITH DE MORAES VEIGA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i 188 MILLIKEN RD., NORTH YARMOUTH, ME 04097 CHRISTINA B. HELDENBRAND/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of P important: if ita any injury or of once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR.3-30-2005 * 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Doseph M. Ostrowsi C.f.S.P. 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final De nica Ka dvonce Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be exacuted nding physician and use as the burial-transil resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Vear in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ sign I be Malnutrita 1 Yes 2 No 3 Probably 4 Henknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 24 No Hospital or Attanding Phyaician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Z Yursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide viithin 24 hours a To tha Funarai f 29a. Certifiei 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title of certified 3.28.01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST CAMBRIDGE 2/6/3 NOMAN 300 AURURA TIMANUY 32. Regimar's Signature 31. Date filed (Month, State 2005 Registrar

		State o - For State Ragistrar amend item #1 per	-		artment of H Sti fice teraf L			giene eg. No. 005	12537
		Decedent's Name (First, Middle, Last)	Twin Sc	HL 4/L	עני לייעני		2. Date of Dea	th	3. Time of Death
Physici	an	Joyce Ann Bond JOYCE	ANNE	BOND			March	Day Yea 26, 2005	11:38 ^{a м}
/Medio		4a. Facility Name (If not institution, give street and nur		DOM	4b City Town or	Location of Death	raten	4c. County of De	
Examir	ęr								
*		Montgomery General Hos 5. Social Security Number 6. Sex		. last birthday)	Oln If Under 1 Year		8. Date of Birth	Montgo	Sirthplace (State or Foreign
Funeral Director		1 M 2 TXF		Vrs	Months Days	Hours Min.	June 19	, Year)	Country) Bw Jersev
		217-36-5817 Usual Residence of Decedent	0	6				,	ew dersey
land		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
Mary f sh	ō	Maryland Montgomery		Pos	kville				1 ☐ Yes 2 ☐ No
28a-	Director	10e. Street and Number		1,00	10f. Zip Code		1	0g. Citizen of What	Country?
with a or		17104 Cherry Valley Co	rt		208	53			SA
s 23	era	10.111	edent Ever in U	IS 13 V	Vas Decedent of Hi		acifu Vas or No-		nerican Indian,
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If the alth and Mental Hygiene. If the properties of the than "natural," or Itams 23a or 28a-f show internal traumatic avent, Its Modified Examinating the notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced 12 Was Deck Armed Fo	rces? 2 🔀 No /e	l t	Yes, specify Cuba	Specify:	Rican, etc.)	Black, WI	
2 hou		15. Decedent's Education		16a. Deced	lent's Usual Occupa	ation	. 1	16b. Kind of Busines	ss/Industry
in 72 n" n	Completed	(Specify only highest grade completed)		(Give	kind of work done of OO NDT use retired	luring most of work)	ing		
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filed Hyg Sthar	Ö	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	
id 2 should be file th and Mental Hy t7 is marked oth traumatic avent	Ω	Ralph Battles				Gladys	Whitloc	ς	
houl of Me mark	2	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	and Number or Run	al Route Number	, City or Town, State	Zip Code)
d 2 s th an 7 is		Paul O. Bond/ Husband						ckville, N	
1 an Heal am 2 thar		20a. Method of Disposition	20b.	Place of Dispos				20c. Location - City	
a for		1 Burial 2 Cremation 3 Removal from	State	cemetery, crem	natory or other plac	- Haic	h 30,		
Fant fant		`4 ☐ Donation 5 ☐ Other (Specify)	G		aven Cemete				ing, Marylan
permit. Pages 1 ar Deparfment of Hea Important: if itam any injury or otha		21. Signature of Funeral Service Licensee		Fr 50	ancis J. O Univer	Collins sity Blvd	Funeral , W, Si	Home Inc. Lver Sprin	ıg, MD 20901
		23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the dea	ith. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition D, 49	2-1-	nt cei	4 ن خ				Onset and Death
/Medical		resulting in death)	or as a conse	quence of):		F230			-
Examiner		ite.	ortdi	4 to4-e	- (vionaly	AIFTY	Digear	ص	
<i>\$</i> 2	ē		or as a conse	quence of):	1 410 4111		,,,,,		
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
exec n an ial-fr	Еха		or as a conse	quence of):					
cate be executed physician and the burial-fransit	dical	C _d							
ficat p phy s fhe	edic	V							
death certific e attending p	Physician/Me	IF FEMALE: 23c. If yes, out						23d. Date of d	elivery
that the death cert ed by the attendin detached for use	ciar	in the past 12 months?	inth 2 Fet		Ectopic pregnancy Other (specify)			Month	Day Year
0 0 0	ysi	1 ☐ Yes 2 No 9 ☐ Unknown							
The law requires that the ite has been signed by thoage 2 should be detached.		Part II. Other significant conditions contributing to de	eath but not re	sulting in the un	iderlying cause give	n in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
signed I	q p	CARDIAL AIRRE	1				1 🗆 Ye	s 2 No 3 1	robably 4 Unknown
w requir been si should	Completed by						24. 116		
sician: The taw requir certificate has been si irector, page 2 should	du						24a. Was a autops perfort	v prior to	autopsy findings available completion of cause of
	S						1 ☐ Yes 3		s 2 No
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only on	θ) (
> 0 TO	္	Hospital:	npatient 2	ER/Outpatient	3 □ DOA Othe	4 Nursing Ho	me 5 🗆 Reside	nce 6 Other (Sp	ecify)
ding Phy h. After fhi funeral	ü	27. Manner of Death 28a. Date of Month	of Injury th, Day Year)	b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	w injury occurred	
endi eath. or: A he fu	atle	2 Accident investigation			M 1 🗆 1	res 2□No			
or Attending after death. Diractor: Afte	ertification:	3 Suicide 6 Could not be determined 28e. Place building	of Injury - At h	nome, farm, stre	eet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
talon saft al Di ed in	Cer		3, (-,						
To the Hospital or Attending is within 24 hours after death. To the Sunaral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) Certifying Physician: To the base and mann and mann	asis of examin	ation and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	ate and place, and du	ie to the cause(s)
To tha within 2 To tha complet	Me	29b. Signature and title of certifier	-		29c. License	number	25	9d. Date signed (Mor	th, Day, Year)
->- o		(Lynn A and a)			DAY	398	M	MECH 2	6rn, 2009
P	-	30 Name and address of the sampleted some	a of death (Ite	m 23a) /Timo 1	Print)	<i>y</i> (0			
		30. Name and address olders in who completed cause	12 m	D1523	15 5HAD	46100412	OAD P	OCTIVILE,	10th, Day, Year) 2005 674, 2005 1991-42 AND
Sta Registr		31. Date filed (Month Day, Year) 32. MAR 2 9 2005	egistrar's Sign	J. Ap	arle				

		For State	State of Ma	ryland / Depa	artment of F rtificate of			000	9"44 P 12 12000 PD
		Registrar		Cei	funcate of	Deam	2. Date of De	Reg. No.	5 1253
Physic /Med		1. Decedent's Name (First, Middle, Las Thelma Elizabeth	Bohrer				Month	25, 2005 Yes	1:30a
Exam		4a. Facility Name (If not institution, give Wilson Health Car 5. Social Security Number 6. Se	e Center	(In yrs. last birthday)	, , , , ,	nersburg If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Birthplace (State or Forei Country)
Directo		579-14-2243 Usual Residence of Decedent 10a. State 10b. County		92 Yrs. 10c. City, Town or Lo	ocation		Nov. 2	2, 1912 We	st Virginia
the Mary 28e-f sh rollfied	rector	Maryland Montgome	ry	Gaithersb	urg 10f. Zip Code			10g. Citizen of What	1X Yes 2 1
Mith 3a or	Ī	301 Russell Avenu			20)877			
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Items 23 or 28e-f show other treumstic event, Ite Medical Exarth at marked other then "health Exarth at must be retilised at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:	>		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	United St 14. Race - A Black, W Specify:	merican Indian,
2 ho	ted	15. Decedent's Ed		16a. Deced	dent's Usual Occup	ation	ina	16b. Kind of Busine	ss/industry
12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r treumatic event, I's Med	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) life.	emaker	during most of work d)	ing	OWn home	
othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	, Maiden Sumame)	
lenta lenta ked ic ev	To B	Hewitt Duval Grov	·e			Grace A	Ann Brow	wn	
shound N		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Numbe	er, City or Town, State	e, Zip Code)
nd 2 lith a 27 is		Ellen Ann Gardine	r (Daught	er) 9665	Fleetwoo	d Court.	Freder	ick, MD 21	701
t Heal Heal Hem othe		20a. Method of Disposition	L (Daagiie	20b. Place of Dispo	sition (Name of		Date	20c. Location - City	
802 = 5	4	1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,		Parklawn	matory`or other plac Memorial	Park 3/2	29/05	Rockville,	Maryland
permit. Pa Departmer Importent: any injury		21. Signature of Funeral Service Licens	600	22	Name and Addre	ss of Facility De er Park I	eVol Fur	neral Homé	
89 E E 9		Sent XX	101			irg, MD 20			
Physician		23a. Part1. Einer the dis, or comp sock, or leart failure. List only of Immediate Lause (Final disease or condition	ne cause on each line	he death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death 1 Week
/Medical Examiner		resulting in death)	α	consequence of):					1 ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events	Due to (or as a	consequence of):					
te be executed ysician and te burial-transit	<u>a</u>	resulting in death) Last	Due to (or as a	consequence of):					
The law requires that the death certificate base been signed by the attending physic page 2 should be detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy			23d. Date of o Month	delivery Day Year
quires that n signed b uld be deta		Part II. Other significant conditions co Colon Diverticulo	-	-				/	to the cause of death? Probably 4 □Unknow
: The law requir cate has been si , page 2 should b	Completed by	Thrombosis, Anemi	a of Chron	ic Diseas	e, Osteoa	rthritis	24a. Was autop perfor	an 24b. Were prior t	autopsy findings availab o completion of cause of ?
		Dementia					1 ☐ Yes		es 2 No
Physicien: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 □Inpatient	2 TER/Outnation	t 3 DOA Oth	26. Place of Death		ne) dence 6 □Other (Si	- agaital
		27. Man fer of Death 1 V Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time of	28c. Injun World	/ at		now injury occurred	эвспу)
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Alter completely filled in by the fune.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y · At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
To the Hospitel or within 24 hours af To the Funerel D completely filled in	edicai C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occurr	and due to the c	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
ompl	Me	29b. Signature and title of certifier			29c. License	a number		29d. Date signed (Mo	nth, Day, Year)
->-0		Halabert Dr	ische	ulhus	D 04	115	F	nauh,	25,2005
5		30. Name and address of person who co	ompleted cause of dea	93	Print)	etros.			, - 1 - 0 -
•	1								

Registrar DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and N - State - Bagistrary MEND#19-2027-EH/ // /05 PMN MCO Certificate of Death	Mental H	ygier	2005	12539
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of I Month	Death	Day Year	3. Time of Death
	/Medic Examin	al	William C. Bennett, Jr. 4a. Facility Name (If not institution, give street and number) Suburban Hospital 4b. City, Town, or Location of Death Bethesda	March	4	2005 4c. County of Death	8:55 p M
	Funeral Director		5. Social Security Number 728 . 12 . 0353	8. Date of E (Month, I March	Birth Da <i>y</i> , Yea	Montgomer 9. Birth Cou 1926 Geo	place (State or Foreign ntry)
	Maryland -f show fled at	tor	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location MD Montgomery Chevy Chase				10d. Inside City Limits 1 ☐ Yes 2 ☐ Yo
	with the 3a or 28a It be notif	I Direc	10e. Street and Number 10f. Zip Code 20815	, ,	10g. (Citizen of What Cou	
98(s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Exercitival funds be notified at	by Funeral Director	11. Marital Status 1 Never Married 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. 14 Yes, specify Cuban, Mexican, Puerto 14 Yes, Sive Year or Dates:	pecify Yes or for Rican, etc.)	No-	14. Race - Ameri Black, White	can Indian,
Maryland 21215-0036	vithin 72 hou ne. hen "nature a Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Attorney	king	16b.	Kind of Business/lr	ndustry
land 2	uid be filed w fental Hygie rked other t	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Midd	lle, Maide		
Mary	d 2 shouth and N		Marie K. Bennett/ Wife 19b. Mailing Address (Street and Number or Run 3513 Hamlet Place Che	ral Route Num	ber, City		•
			20a. Method of Disposition 1 □ Burial 2XXCremation 3 □ Removal from State	Date	20c.	Location - City or T	own, State
Baltimore,	permit. Page Department of Importent: If any Injury or once.		14 □ Donation 5 □ Other (Specify) 21. Signature of Turna Service Licensee 22. Name and Address of Facility Jo 5130 Wisconsin Ave	seph G	awle	r's Sons,	Inc.
•	Priysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):		arrest,		Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	clan/Medical	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of deliv Month	ery Day Year
Is, P.O.	ires that the de signed by the a 1 be detached	by Phys	9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o use contribute to	
H thy		Completed		24a. Wa	as an topsy rformed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
₹ A Nital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Dear Hospital: 1 From Patient 2 FR/Outpatient 3 DOA Other: 4 Nursing Hospital: 1 FR/Outpatient 3 DOA Other: 4 D			6 □Other (Speci	fy)
ion oi			27. Manper of Death 1 Natural 5 Pending 2 Accident investigation 28a. Da e of Injury (Month, Day Year) 28b. Time of Injury 8b. Time of Injury 9c	28d. Describ	e how in	jury occurred	
FNN F	or At offer o	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street own, Sta	and Number or Rur ate)	al Route Number,
B	To the Hospital within 24 hours e To the Funeral completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.				
	To ti Withi To ti comp	X	29b. Signature and title of certifier Patricia Tomske May, Mad D51916		29d. C	pate signed (Month,	Day, Year) 2005
	20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pike, G-/	100, Rc	cki	ville, MU	20852
	Sta Registr		31. Date filed (Manifelty, Y2r) 9 2005 32. Segistrar's Signature Apartic			/	

			1- For State MENI#10a/cperFH3/	State of Mary 29/05.dos.M		artmen <i>rtificat</i>			nd Me	ental Hy	7	005	***	2540
			Decedent's Name (First, Middle, Last)							2. Date of De		- 0 0		3. Time of Death
	Physic		Claire Barsk	TV.						Month March	Day			4:45 PM M
	/Medi Examir		4a. Facility Name (If not institution, give stre	-		4b. City,	Town, or	Location of	Death	1101		County of E		HI43 PM
			Suburban Hospital			Beth					Mc	ntgon	nery	
	Funeral		5. Social Security Number 6. Sex	2 N F	yrs. last birthday)	If Under Months	1 Year Days	If Under 24 Hours	Min.	B. Date of Bir (Month, Da	y, Year)	9.	Birthplac	e (State or Foreign
	Director		577-05-3548 Usual Residence of Decedent	X 87	Yrs.				J	July 5	, 191			and, N.J.
	land ow		10a. State 10b. County	10	c. City, Town or Lo	cation							10d	. Inside City Limits
	Mary -f sh	ţ	D.C.	T.	ashingto	n <u>P-C</u>								1 X Yes 2 □ No
	r 28a	rec	10e. Street and Number	W	asiiiigto	10f. Zip					10g. Citiz	zen of Wha	t Country	?
	th with	a D	3001 Veazey Terr N.W	. # 811		20	800				US	A		
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or flems 23a or 28a-f show ther, If a Medical Exerting trust be rectified at	Funeral Director	11. Marital Status 12.	Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Deced	dent of Hi	spanic Origi	n? (Spec Puerto R	ify Yes or No ican, etc.)	- 1	14. Race - A	American Vhite, etc	
36	or It	J.	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1 □ Yes		Specify:		, ,		Specify: W		
Ö	hours ture!	d by	3 Widowed 4 Divorced	Year or Dates:										
7-	n 72	Completed	15. Decedent's Educat (Specify only highest grade of		16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	ition <i>luring m</i> ost o)	of working	7	16b. Kir	nd of Busine	ess/Indus	stry
12	with ene. ther	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	Buyer			'			Ret	ail S	tore	:
b	be filed within 72 ho ital Hygiene id other then "natur event, If a Madical	BeC	17. Father's Name (First, Middle, Last)					18. Mother:	s Name (First, Middle,	. Maiden .	Sumame)		
<u>a</u>	uld be denta rked tic ev	To B	Benjamin Blaker					Unkn	own					
Maryland 21215-0036	s 1 and 2 should be filed within 'f Health and Mental Hygiene. item 27 la marked other then "other traumatic event, II a Mo.	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address	(Street a	and Number	or Rural	Route Numbe	er, City or	Town, Stat	te, Zip Co	ode)
	os 1 and 2 of Health item 27 I		Hyman J. Barsky / Hu	sband	3001	Vease	y Te	rr. #8	11,	Washir	igton	DC 2	8000	
ore	of He fiten r oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem		20b. Place of Dispo cemetery, crer	sition (Nan matory or o	ne of ther place	9)	Da	te	20c. Loc	cation - City	or Town	, State
Ē	ortent: If ortents of injury or		`4 □Donation 5 □ Other (Specify)		Mt. Comfo					-		andri		
Baltimore,	permit. Pages: Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Ligensee	140					-	h Gawl			-	
	<u>v</u> □ = e o		X aux							.W., W		ngton	1	
			shock or heart failure. List only one	ions that caused the cause on each line.	death. Do not ent	er the mod	e of dying	g, such as ca	ardiac or	respiratory a	rrest,		In	pproximate terval Between nset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Diff Co										
	Examiner			Due to (or as a co										
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	Septice:										
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c											
Ć,	exection and items	Exa	resulting in death) Last	Due to (or as a co	nsequence of):									
8760,	cate be executed physician and the burial-transit	dicai	d.											
9		ெ												
Вох	death certifii e attending p id for use as	Physician/M	23b. was decedent pregnant	If yes, outcome of p 1☐Live birth 2☐		Ectopic pr	egnancy				2	3d. Date of	,	
	D 0 0	sici	in the past 12 months? 1 ☐ Yes 2 XNo	4□Pregnant at time 9□Unknown		Other (sp						Month	Da	y Year
P.0	that the de ed by the a detached	Phy	9 Unknown		A					00 - Did 4				
	es pe pe	ρχ	Part II. Other significant conditions contrib Coronary Obstructive				ause give	in in Paπ I.			obaccous res 2□		e to the c	ause of death? y 4 🗇 Unknown
oro	w requir been s should	ted	Colonaly Obstituctive	e i uimona	Ly Diseas				_		105 2			T
Sec.	The law cate has b page 2 s	Completed								24a. Was autop		prior	to compl	findings available letion of cause of
al F										1 ☐ Yes	2 12 No	death 1 🗆 N		2 No
Vital Records,	5 8 9	Be	25. Was case referred to medical examiner?	pital:	-5		Othe	r		Check only o				
of		-: To	1 492 5 140	1 Pinpatient 28a. Date of Injury	2 ER/Outpatien		A	4 🗆 Nurs		d. Describe h			Specify)	
on	ding I h. After funer	tion	1 🗗 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	м	8c. Injury Work 1 □ Y	? ′es 2 ∐ No						
Division	or Attending after death. I Director: Afte d in by the fune	Certification;	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, str	eet, factory	, office		28			Number or	Rural Ro	oute Number,
á	al or A s after I Dire	ert	4 Homicide	building, etc. (S	(pecify)					City or Tov	vn, State)			
	popition in popiti		29a. Certifier 1 Certifying Physici	en: To the best of m	y knowledge, death	occurred a	at the tim	e, date and	place, an	d due to the	cause(s)	and manner	r as state	d.
	he He in 24 he Fu	Medical	(Check only 2 Medical Exeminer one)	and manner stated.	imination and/or in	vestigation,	in my op	inion, death	occurred	at the time,	date and i	place, and	due to the	e cause(s)
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Σ	29b. Signature and title of additier			29c	. License	number			29d. Date	signed (M	onth, Day	v, Year)
)			late 1				200	161300	2_	1	Marcl	n 26,	2005	5
	20		30. Name and address of person who comp				4		0.01.1					
			Atul Rohatgi, 8600 O					MD 20	0814		-			
	Sta Registr		31. Date filed (Month Pay, Year) 9 200	5 Pagistial S	Signature	merke	7							

		For State Registrar 1. Decedent's Name (First, Middle)	State of Marylan			lealth and M	Reg.	ne 2005	12541
Physicia		NATASHA		DA	Omio			Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution,	ALIYAH give street and number)	DAU	4b. City. Town. o	r Location of Death		2005 4c. County of Death	7:04 a [™]
Lamin	Ç!	4649 Columbia I				tt City		Howard	
Funeral			6. Sex 7. Age (In yrs.	last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
Director		167 70 8657	1□ M 2 X F 31	Yrs.	Months Days	Hours Min.	(Month, Day, Yea	1973 Wash	ington, D.
pue *	1	Usual Residence of Decedent 10a, State 10b, County	10c Cit	y, Town or L	ncation				
Aaryti I sho	ŏ	/						[1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
h the Marylan r 28a-f show	rect	PA Bucl	CS	Ste	wartstowi 10f. Zip Code	1	100	Citizen of What Cour	
eth with 23a or	0	3 North Sycamor	te I.ano		Tot. Zip Gode	17363	109.		iuy?
72 hours after deeth with the Maryland 72 hours after deeth with the Maryland naturel', or Items 23a or 28a-f show Alcal Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of h	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Americ	
rs after de		1 Never Married Marrie					Rican, etc.)	Black, White,	etc.
d 2 should be filed within 72 hours alf the and Mental Hygields of 157 is marked other than "natural", or traumatic event, it a Modical Examples.	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Yes 3€No	Specify:		Specify: W	hite
"natur	Be Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done	ation during most of worki	ing 16b.	Kind of Business/Inc	dustry
within ene.	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	life.		•			
Hygir Hygir III	ပ္	17. Father's Name (First, Middle, L	5+ ast)		Therapis		e (First, Middle, Maid	Self Emp	Loyed
d be ental ked o	To Be	Shamin Bacchus				Rehanna		en Sumame)	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It a M	<u> </u>	19a. Informant's Name/Relationshi	Charles and the Assessment Control of the Control o	19b. Maili	na Address (Street		L Kazim N Route Number, City	or Town State Zin	(Code)
nd 2 alith a 27 is r train		John P. Magee /					Stewartst		
rmit. Pages 1 and 2 partment of Health portent: If item 27 I y injury or other tre	7	20a. Method of Disposition	20b. P	ace of Dispo	esition (Name of matory or other place	1		Location - City or To	
Pages nent of I		1	DIMONIOVALITOTTI STATE				/2005 Ad	-1-1-2 24	1
permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event. It am 1000.		21. Signature of Funeral Service Li		22	2. Name and Addre	s of Facility Hin	es Rinald:	eipni, Mai i Euroral	y Land
88888		tour	Menton -	- 1	1800 New	Hampshire	Ave Silve	er Spring	MD 20904
Physician /Medical Examiner	Iner	shock, or beart failure. List o Immediale Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Strangulation Due to (or as a consequence) Due to (or as a consequence)	ience of):					Interval Between Onset and Death
ate be hysicia he bui	Exa	Cause (Lisasse or fine) that initiated events resulting in death) Last	c	ence of):					
The law requires that the death certifica tle has been signed by the attending pt oage 2 should be detached for use as t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9★★Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	ry Day Year
es the	2	Part II. Other significant condition	s contributing to death but not resu	lting in the u	nderlying cause give	on in Part I.	23e. Did tobacco	use contribute to the	
	Completed						24a. Was an autopsy performed?	prior to com death?	sy findings available apletion of cause of
ysician: is certifica director, p		25. Was case referred to medical examiner?				26. Place of Death			
hys this al dii	0	XX es 2 No			t 3□ DOA Othe	4 Nursing Hor	ne 5 🗌 Residence	6 XX ther (Specify)	at scene
	Certification	27. Manner of Death 1 ☐Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how inju	ury occurred	
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or Attendater death		4 K Homicide determin	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office	2	8f. Location (Street a City or Town, Stat	nd Number or Rural (e) 4649 Col	Route Number, umbia Rd
pltel ours a erel l		29a Certifier 1 ☐ Certifying	Found in park	ing lo)t	Ho	ward Coun	tv. Marvl	and
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel to the funerel or the funerel o	60	(Check only one) Medicel Ex	Physicien: To the best of my know aminer: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause(s d at the time, date an	s) and manner as sta nd place, and due to	ited. the cause(s)
To To Com		29b. Signature and title of certifier	. ~	-	29c. License	number	29d. Da	ate signed (Month, D	lay, Year)
		Theorem &	1. Kytuus		OCM	3	Ma	rch 9, 20	05
12	:	and the same of	no completed cause of death (Item :	23a) (Type, f	Print)				
		itteroore Mik		111	enn Stre	et , Balt	imore, Mar	yland 21	201
State Registra	-	31. Date filed (Month AR Year)	2005 32. Rigistrar's Signatu	S- A	2545		-	_	

			1 - For State Registrar	State of Ma	aryland / Depa	artment of H			6	005	12542
			Decedent's Name (First, Middle, III)	ast)			- Cui,,	2. Date of Da	Reg. No. ath		3. Time of Death
	Physici /Medio		Florence G. H	Sowling				March	29.	200 ^{Year}	5:20A.M.
	Examir		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of D			ounty of Dea	
			Waldorf Health	care Cent	er	Waldori	£		Cł	narle	S
	Funeral			1 D M 200 E	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Bird Min. (Month, Da	h	9. Bir	thplace (State or Foreign
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	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Man Fireh	tor	MD Char	100	Waldor	£					1 ☐ Yes 2√∑ No
	n the	Director	10e. Street and Number	100	Waldol	10f. Zip Code			10g. Citize	n of What Co	ountry?
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	r dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.1		ispanic Origin?	(Specify Yes or No			erican Indian,
36	ours after death with the Marylan ral', or Items 23a or 28a-f ehow Exeminer must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 📉 Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes 2X No	Specify:	, , , , ,	S	ecify:	0, 010.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 ehow ha Marical Examinat must be notified at		15. Decedent's	Year or Dates:	162 Dece	dent's Usual Occupa	ation			Wh	ite
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212	e filed withl at Hyglene. I other than vent, Ine M	E O	Elementary/Secondary (0-12)	College (1-4or 5		memaker				Home	۵
	be filed within 72 hours ital Hygiene. Id other than "natural", event, the Moder Exe	Be	17. Father's Name (First, Middle, La	st)			18. Mother's I	Name (First, Middle,	Maiden Su		
yla		To I	J. Enoch Garne	r		M	Mirand	la Elizal	oeth	Will:	iams
Maryland	S S S		19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a	and Number or	Rural Route Numbe	er, City or T	own, State, 2	Zip Code)
	s 1 and 2 if Health item 27	. 6	Melvin B. Bowl 20a. Method of Disposition	ing/ Son	P.O. 20b. Place of Dispo	Box 836	La_P	lata, Mi			
altimore,	Pages nent of H int: if ite		1 Burial 2 ☐ Cremation 3		rinity		9 - 41	2/2005			Town, State
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	Physician		Immediate Cause (Final disease or condition	_a Pulmon	ary Embo	lism					Onset and Death Few Weeks
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
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σ.	that the ded by the detached	۵.	Part II. Other significant conditions	contributing to death bu	at not resulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
Records,	requires that the een signed by th nould be detache	d by	Dementia					1 □ Y	es 2 √ ∑N	lo 3 Pr	obably 4 🗀 Unknown
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Re	The law ate has b page 2 si	Completed						autop: perfor	med?	prior to death?	completion of cause of
Vital		0	25. Was case referred to medical				26 Place of F	1 ☐ Yes Death (Check only or	200 No	1 Ll Yes	2C No
	lis ce direc	To B	examiner? 1 ☐ Yes 2X No	Hospital: 1 Inpatier	nt 2 EP/Outpatient	Otho	p-	g Home 5 ☐ Resid		Other (Spec	cify)
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Division	ii or Attendater deatl Director: Jin by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and N n, State)	umber or Ru	ral Route Number,
	Hospitai		29a. Certifier 1X Certifying F	hysician. To the best	f my knowledge = == "	Coordinate to the terminate of the termi	o dot 1	il			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filted in by	edical		Physician: To the best of iminer: On the basis of and manner stat	examination and/or inv	restigation, in my opi	e, date and pla inion, death of	ace, and due to the courred at the time, d	ause(s) and late and pla	manner as ce, and due	stated. to the cause(s)
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•			Van	1		D 44	436	M	larch	29,	2005
1	RU		30. Name and address of person who								
4	- CV		Ashvin J. Pate 31. Date filed (Month, Day, Year)	1, M.D. I	UZ Paul N	Mellon C	t., S	uite 102	Wal	dorf,	MD 20601
	Sta Registr	4	MAR 3 0	2005	r's Signature	back					

			1 - State Registrar	State of Maryla			of H	ealth a	ind Mental I		ne 2005	L2543
	Physic	ian	1. Decedent's Name (First, Middle, I John Frank Blis	,					2. Date o Month		ay Year	3. Time of Death
	/Med Exami		4a. Facility Name (If not institution,			4h City 1	Own or	Location of	Mer		1c. County of De	
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	Funeral			Sex 7. Age (In yrs	s. last birthday)	If Under Months	Year	If Under 2	4 Hrs. 8. Date of	Birth Day, Yea		rthplace (State or Foreign Country)
	Director		176-20-1444	1□ X M 2□ F	77 Yrs.	Months	Days	Hours			8,1927	PA
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Mary -f eh	ţŏ	MD Ceci		Rising.							1 ☐ Yes 2 No
	h the	Director	10e. Street and Number	,	tre-creg .	10f. Zip (Code			10g. C	Citizen of What C	Country?
	23a c	aiD	442 Telegraph 1	Road		219	1 1				SA	·
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decede	ent of His	panic Orig	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am	
36	rs afte	by Fi	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2		Specify:	T don't i llouit, oto.		Black, Wh	
8	be filed within 72 hours after death with the Maryland hal Hygiene. sd other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be inclified at	ed	15. Decedent's	Year or Dates:	16a. Deced	lent's Usual	Occupat	tion		105	u	Vhite
215	hin 72	Completed	(Specify only highest of	rade completed)	(Give	kind of work OO NOT use	done du retired)	uring most	of working	160.	Kind of Business	s/Industry
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nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	st)				18. Mother	's Name (First, Mid	dle, Maide	n Surname)	
Z	2 should be filed withli n and Mental Hygiene. is marked other than raumatic event, Ita M	ည	Frank Blisard						a Parker			
Maryland 21215-0036	S 80 50		19a. Informant's Name/Relationship Donna Blisard/w						or Rural Route Nu			
	Health Health tem 27 i		20a. Method of Disposition	0					, Rising			
Baltimore,	Pages nent of i		1 Burial 2 Cremation 3	_ indinoval from otato	Place of Dispos cemetery, crem				3-30-2005		Location - City or	
Ħ	유민준 등		21. Signature of Funeral Service Lice		1. Foa	rd tur Name and	1era Address	of Facility	e, P.A.	Ke.	sing Sun	i, MD
m	Depa Impo any is		1 hard	L Clark	1	11 S.	Que	2n St	. Risina	ra Fi Sun	ineral H . MD 21	lome, P.A. 911
	Physician /Medical		23a. Part1. Enter the disease/or conshock, or heart failure. List only Immediate cause (Final disease or condition resulting in death)	nplications that caused the dea y one cause on each line. a. Emphy	th. Do not ente	er the mode	of dying,	such as ca	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
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۳.	s thet ned b e deta	y Pł	Part II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cau	se given	in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
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ita i	sien: artific ctor,	Be (25. Was case referred to medical examiner?				2	6. Place of	1 ☐ Yes Death (Check onl) I Tes	2 No
Division of Vital	Physicien: The lav this certificete has al director, page 2	2	1 ☐ Yes 2/X No		ER/Outpatient	3□ DOA	Other:	4 🗌 Nursi	ng Home 5/2 Re	sidence	6 ☐Other (Spec	cify)
u C	ling F	lon:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		. Injury a Work?	t	28d. Describ	e how inju	ry occurred	
2	death death stor: / the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М		s 2 No				
ΩÍ	To the Hospital or Attending Physicien: The law requires thet the within 24 hours attended. To the Funeral Director After this certificete has been signed by the completely filled in by the funeral director, page 2 should be detached.	i Certification:	4 Homicide determined	building, etc. (Specif	y) 				City or 1	own, State	ə)	iral Route Number,
	the Hosy nin 24 ho the Fune npletely f	ledicai	29a. Certifier (Check only one) (Check only one) (Check only one)	nysician: To the best of my knominer: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at estigation, in	the time, my opin	date and pion, death	place, and due to the control occurred at the time	e cause(s e, date and) and manner as d place, and due	stated. to the cause(s)
	To To	Σ	29b. Signature and title of certifie			29c. L	icense n	umber			te signed (Month	
		-	1 perla	omp		71	57	114		May	d 29, 2	-005
	2		30. Name and address of person who	completed cause of death (Item	1 23a) (Type, P	rint) 22	9 E.	Mair	n St.Elkt	on, N	ND 2192	1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sigra	ture	20	', /	'/				
	Registr	ar	MAR 3 0 200	5 1000 000		And Wall						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #4c, 4-1-05, per Dr. Certificate of Death

HCHD, al Amend #11,4-1-05, Der FHDR HCHD al Reg. No. 1. Decedent's Name (First, Middle, Last) per FHDR, HCHD, al 3. Time of Death A 2 Date of Death Day Bokn Month 3 03:44 M **Physician** Olga 30 2005 elen , /Medical 4c. County of Death 4b. City, Town, or Location of Death NONE 4a. Facility Name (If not institution, give street and number) Examiner Ball Baltimore C:+ Hospital Kernan If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 10/29/1929 Birthplace (State or Foreign Country)
 Ohio 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 = 283 24 6519 75 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral, or Itams 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Ellicott City Howard 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 4079 Choctaw Drive 21043 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1X Yes 2 No 1951-Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates: 1955 Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked oth any jury or other traumatic event 2008: Be John Cap, Sr. Mary Gadosh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Walter J. Bohn/ Husband 4079 Choctaw Drive Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State Metro Crematory 3/30/2005 Catonsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. -Attle moroyy Collins 4112 Old Columbia Pk Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Braza Failure Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Fibrillatin COPD Atrial 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed resul 21 cer 2 No 1 Yes 2 No 1 TYAS funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mapher of Death or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funarai D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0044 635 03,30,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bollimore, Md. 21207 2200 Kernan Drive Harrison Joha'

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAR 31

2005

32. Redistrar's Signature

			1 - For State Registrar	State of M		/ Dep	artment of rtificate of	Health a	and Me	ental Hy		2005	12545
			1. Decedent's Name (First, Midd	le, Last)						2. Date of Dea			3. Time of Death
	Physici /Medio		VERNA	DAVIS	ва	RBE	R		1	Month MARCH	Da 2 6	y Year 2005	10:57A M
	Examir		4a. Facility Name (If not institution	n, give street and number			4b. City, Town,	or Location of	of Death			County of Death	-l
			FREDERICK 1	MEMORIAL H	OSPITA	L	FREDI	ERICK				FREDERI	CK
	Funeral		5. Social Security Number		ge (In yrs. last	birthday)	If Under 1 Yea Months Day	r If Under:	24 Hrs. Min.	8. Date of Birti (Month, Day	h		place (State or Foreign
	Director		219-20-1907	1□M 2\\ F	86	Yrs.	Wionins Day	s Hours	MICI.	June 2	5.19		vland
	pu »		Usual Residence of Decedent 10a. State 10b. County		ton City T								
	anyla etho	~	Too. State		10c. City, To] 1	10d. Inside City Limits
	8a-f	Sct	Maryland Frede	erick	│ Wa1ke	rsvi							1XXYes 2 □ No
	vith th	ä	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Cour	ntry?
	ath v 23e	ra	60 Main Street				21793				Unit	ed Stat	es
	er de tem	nue	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Decedent of If Yes, specify Cu	Hispanic Original Hispanic Origin Hispanic Origina Hispanic Origina Hispanic Origina	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		 Race - Americ Black, White, 	
36	s aft	γF	1 ☐ Never Married 2 ☐ Mar 3XXWidowed 4 ☐ Divorced		χ ν ο		1 ☐ Yes 210 N						
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28s-f show he Madical Examitrations the notified at	Completed by Funeral Director										AALTI	
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2	filed Hygi ther	ŏ	17. Father's Name (First, Middle,	<u> </u>	<u> </u>	amin	istrativ			First, Middle,			epartment
a	d be antal ced o	o Be									waiden	Jumame)	
2	should Me mark	P	Warren G. Davi 19a. Informant's Name/Relations		1	9h Mailir	a Address (Stree		el Bes		. Cit. o	r Town, State, Zip	C- d-1
Maryland	d2s than than trau	1	Robert Barber/										(Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Iteme 23a or 28a-1 ehow any injury or other traumatic event, the Madeal Examiner must be notified at once.		20a. Method of Disposition	3011	20b. Place	of Dispo	Sweet Ai	I KOSO	1/ PNC			Z1131 ecation - City or To	nun State
Baltimore,	ages nt of t: If if		XX Burial 2 Cremation	3 Removal from State	ceme	tery, crei	natory or other pl	· !			200. 20	oution only or re	mii, State
₫	it. Puritme		' 4 □ Donation 5 □ Other (S 21. Signatur of Funeral Service		Mt. H	ope	Cemetery	A	pril.	1,2005	W	oodsbore	, MD
Ba	Depa Impo any i		21. Signatur on Purietal Service	St 1	1	1	Name and Addi	ress of Facility	Stai	ıffer F	'une	ral Home	s, P.A.
			1 ounmey	Jauf,	en	4	J Fulton	Avenu	ie/Wal	lkersvi	.11e	, MD 217	93
k.			23a Part1. Enter the disease of shock, or heart failure. List	only one cause on each I	ine.	o not ent	er the mode of dy	ring, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Priysician	1	Immediate Cause (Final disease or condition resulting in death)	_aU	20507	315							LUZEK
Н	/Medical Examiner		rosalling in dodiny	Due to (or as	a consequenc	e of):							
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760,	ate be executed hysician and the burial-transit	lcal E				.0 017.							
8	death certificate be executed e attending physician and id for use as the burial-transit	glo		d.									
9 ×	leath certific attending p I for use as I	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy								
Box	atten for u	slan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal dea		Ectopic pregnand	су			2	23d. Date of delive Month	ry Day Year
o	at the de by the a tached	ysk	1 ☐ Yes 2 至No 9 ☐ Unknown	9 Unknown	t time or death	5	Other (specify)				1		
0.0	res that I	린	Part II. Other significant condition	ons contributing to death b	out not resulting	in the u	iderlying cause o	ven in Part I.		23e. Did tol	pacco u	sa contribute to th	e cause of death?
Vital Records,	sign d be	d by		DIUM DIFIC							es 🗶	,	ably 4 □Unknown
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ĕ	The law requires that the ste has been signed by the page 2 should be detached.	Completed	Heere	ROWAL FA	VICOSE.	-				24a. Was a autops	y	prior to con	psy findings available inpletion of cause of
<u></u>	/sician: The law s certificate has b director, page 2 s									perform	No	death?	2 No
Ž	or Attending Physician: uter death. Director: Atter this certifics in by the funeral director, i	Be	25. Was case referred to medical examiner?	Magnital: 1						Check only on			
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Division of	or A	iti	4 ☐ Homicide determ	inord 286. Place of Ini	ury · At home, c. (Specify)	tarm, stre	et, factory, office		281	Location (St. City or Town	reet and n, State)	d Number or Rural	Route Number,
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier th Certifyin (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis o	i examination a	ge, death and/or inv	occurred at the to estigation, in my	ıme, date and opinion, death	place, and cocurred	due to the ca at the time, da	ause(s) ate and	and manner as sta place, and due to	ated. the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year JACK BEHNER 2005 1:30 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours NEM 2□F 73 Director 18, 170 26 9737 Pennsylvania 1931 Usual Residence of Deceden the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Exercitor must be notified at Director 1 ☐ Yes 2X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. other then "natural", or Items 23a or 3010 Greenway Drive 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ∑XYes 2 □ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1952-54 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Manager Tire & Rubber Co. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H 7 is marked ot Be permit. Peges 1 and 2 should be Depertment of Health and Mental Importent: If Item 27 is marked c any injury or other treumatic eve since. Wilmont Benner Myra Derk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera L. Benner/Wife 3010 Greenway Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4-4-2005 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RES / Mphy
Due to (on s a consequence of): Priysician XATIVING /Medical Examiner Emplysemen Sequentially list conditions, any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No 2 🗆 No of Vital 1 Yes 1 TYAS or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☐ ₩6 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident efter death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerei I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signafule and title of certifier 29d. Date signed (Month, Day, Year) 0-34868 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11055 Litter Patricia 31. Date filed (Month, Day, Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 0,567 AM avmon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death tospital (enter arvol Nestminster arro If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 🙀 M 2 🗆 F 70 217-28-7435 Yrs Director 21, 1934 Tennessee Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Frederick New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23e 15314 New Windsor Rd. United States

14. Race - American Indian,
Black, White, etc. death Funeral 21776 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ White Specify: 3 X Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) ges 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 Is marked other than Elementary/Secondary (0-12) 5th College (1-4or 5+) Construction F.O. Day Builders 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley Bryant Bertha (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Minnick (daughter) other t 4400 Jenny Ct. Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it eny injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Cem. 3/30/2005 Cooksville, MD 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, A o i a e Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 25case /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed estive Due to (or as consequence of): burial-Box 68760. physician tailure Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? diabe page 2 s autopsy performed? 1 ☐ Yes 2 🗆 No 2. No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a

To the Funerel C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 30. Name and address of personthe completed cause of death (Item 23a) (Type, Print) 4 Woodbine MD 108C LISION D.O. tapoi 15en Jamin 31. Date filed (Month, Day, Year) 32. Restrar's Signature State MAR 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 30 2005 2:32pm BARBER, JR. OSCAR IGNATIUS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Months **X**IXM 2□ F Yrs 61 Director 217-42-8504 JAN. 29, 1944 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State 28e-f show other treumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2 ☑ No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "netural", or Items 23a 1084 HOPEWELL 20646 PLACE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1X Never Married 2 Married 1 ☐ Yes ¾ No Specify: Specify: BLACK If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry WASHINGTON SUB. Elementary/Secondary (0-12) College (1-4or 5+) 12 LABORER SANITARY COMM. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be OSCAR IGNATIUS BARBER, SR. IDA F. LYLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is rang any injury or other treum MARY O. JACKSON-SISTER 1084 HOPEWELL PLACE, LA PLATA, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) TR TRINITY MEMORIAL GDNS. 4-5-05 WALDORF, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00479 SERVICE, AND 20646 RAYMOND FUNERAL PLATA, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** heart Disease schemic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 WUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🙀 No 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospitel or Attending P 24 hours after death. e Funerel Director: After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier yah.a 129001 March 31 2005 D-50883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YAHIA TAGOURI MD 25500 PT LOOKOUT RD LEONARDTOWN MARYLAND 20650 32. Registrar's Signature 31. Date filed (Month, Day Year) State Registrar

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		•	1 - For State Registrar		- ,	rtificate of			2005	12550
15			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
В	Physicia /Medic		MARY JANE E	ERENS				Month MARCH	Day Year 31, 2005	2:26P ^M
10	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
*			2765 MORAN DRIV			WALD If Under 1 Year		100		ARLES
	Funeral Director		5. Social Security Number 6. Sex	M 2 TYF	(In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
			301-22-7969 Usual Residence of Decedent	7	6			NOV.4,	1928 0	HIO
	irylan show	_	10a. State 10b. County		10c. City, Town or l					10d. Inside City Limits
	sa-fa	Director	MARYLAND CHARLE	S	WALI					1 ☐ Yes 2 No
	with ti		10e. Street and Number			10f. Zip Code	0.7	16	og. Citizen of What C	•
	leath	Funeral	2765 MORAN DRIV	E 2. Was Decedent Ev	ver in U.S. 13	. Was Decedent of h		ecify Yes or No-	14. Race - Am	S.A. encan Indian,
ري وي	after d	Fun	1 Never Married XIX Married	Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yes, Give	0		Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
ĕ	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23e or 28e-f show ent. It a Medical Evana et must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2/☐/No	Specify:		Specify:	WHITE
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Q 0	filed Hygir other	Be Cc	17. Father's Name (First, Middle, Last)		HOM	3HAKLIK	18. Mother's Nam	e (First, Middle, A		715
a	lid be fental rked o	ToB	GEORGE DE SILVE	STER			ANGELI	NA VERR	OCHIO	
ary	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene "natural", or Items 23a or 28a-f show flem 27 is marked other than "natural", or Items 20a or 28a-f show other traumatic event. Ite Medical Evantary must be notified at		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mai	ling Address (Street	and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health em 27 ther tra		DONALD F. BEREN	IS-HUSBA			DRIVE,			0601
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition ↑□Burial 2 □ Cremation 3 □ Re	moval from State	20b. Place of Disp cemetery, cri	osition (Name of ematory or other pla	ce)	Date	20c. Location - City of	r Town, State
Ē	it. Pages rtment of rtant: If ii njury or c		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			PER'S CE		4-4-05	WALDORF,	MARYLAND
Ba	permit. Pages 1 an Department of Heal Important: if Item 2 eny injury or other once.		21. Signature of Funeral Service License	M00479		RAYMOND	FUNERAL			
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations hat caused t	he death. Do not e	A PLATA	MARYI.	AND 20 or respiratory arre	646 est,	Approximate Interval Between
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Вох	th cer tendir r use	an/N	230. Was decedent pregnant	c. If yes, outcome o		□Ectopic pregnanc	y		23d. Date of de	,
о. П	e dea the att	sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at ti 9☐Unknown		Other (specify)	<u></u>		Month	Day Year
Ρ.	that the death certifical ed by the attending phi detached for use as th	Completed by Physician/Med	Part II. Other significant conditions conf	ributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e, Did tob	acco use contribute t	o the cause of death?
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CO	w req	lete	11	- Berg				24a. Was a	n 24b. Were a	utopsy findings available
Re	rhe ia te has age 2	шо	- Martin					autops:	y prior to ned? death?	completion of cause of s 2 No
ita	ien: Trifica	a	25. Was case referred to medical				26. Place of Deal	1 ☐ Yes 2		2 2 10
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	To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy gompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Examination)	er: On the basis of and manner state	examination and/or i	nvestigation, in my	opinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)
	To ti To ti	Σ	29b. Signature and title of certifier	1.12		29c. Licen			d. Date signed (Mon	th, Day, Year)
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١	IL'		30. Name and address of person who con HENRY BURKE, 11	npleted cause of de . 5 LA GR			дта. мг	20646		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Violet Mae Schildt-Beck 0041 M Ap. Li 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Feb 19, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Months Days 1 ☐ M 2 🖫 F 196-14-1279 90 Director Feb Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at Completed by Funeral Director MD Washington Hagerstown 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18013 Par Three Drive 21740 USA or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: 3 X Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machine operator 8 Clothing mfg. other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked other any lightly or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jacob E. Fleagle Bertha P. Deal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14117 Edgemont Road. Smithsburg, MD 21783 Joyce E. Shockey daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Washington TWP 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☑Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harbaugh Church Cem. Apr 8, 2005 Franklin CO, FA

22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1000 50 S. Broad ST. Waynesboro, PA 17268 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of wind such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ouran /Medical Due to (or as a cons que Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a construence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2₺ ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Ó 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2 s certificate 2 □ No 1 Tyes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 1 Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After th 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending investigation 1 🗌 Yes 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical the and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

Replacement Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Lawrence Maxwell Bucans March 25, 2005 10:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Prince George's Renaissance Gardens If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☐ F Director 083-01-3512 98 July 31. New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. tnside City Limits 28a-f show the Medical Examiner must be notified 1 Yes 2x No Director Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 23a 3116 Gracefield Road 20904 USA death Funeral lams ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Black, White, etc. filed within 72 hours after 1 □XYes 2 □ No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Unknown "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Coltege (1-4or 5+) Linguist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fil of Health and Mental H fitam 27 Is marked otl Be Herman Bucans ပ Jessie Mincho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine A. Bucans/ Wife 3116 Gracefield Road, Silver Spring, MD 20904 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State March 27, = ŏ permit. Page Department of Important: If any injury or once. 4 ☐ Donation \$\int 5 ☐ Other (Specify) Metropolitan Crematory 2005 Alexandria, Virginia un ral Service Licen 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature q 500 University Blvd, West, Silver Spring, MD 20901 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Accident Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Ur Jarring Cause (Disease or injury that initiated events resulting in death) Last Intracranial Bleed Months Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Atherosclerotic Cardiovascular Disease Years Due to (or as a consequence of): Box 68760 Physician/Medical attending p tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has cate 2 X No 1 ☐ Yes Division of Vital To the Hospital or Attanding Physician: certific director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 KNatural Injury 5 Pending death. 1 🔲 Yes 2 No investigation 2 Accident Diractor 6 Could not be determined 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier cal 1 🖵 X ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ar D24035 April 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Eugenio Machado, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State 06 APR Registrar

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	Funeral		5. Social Security Number 6. S 178–26–1696	Sex 7. 1 □ M 2 😾 F	Age (In yrs. last birthda 71 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth Oct. 13,19	9. Birth	place (State or Foreign ntry)
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "neturel; or Items 23s or 28s-f show or other treumatic event, the Medical Examiner must be notified at or other treumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 6351 Spring Ridge	e Parkway	#214	10f. Zip Code 2170	1	10g.	Citizen of What Cou USA	ntry?
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сошро	Me	29b. Signature and title of certifier Accho Da	m MD			29c. Licens	e number 7541		29d. Date sig		-
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:50 P M CONSORTI MARCH 28, 2005 **PASQUALE** /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6751 ALLENTOWN RD. TEMPLE HILLS PRINCE GEORGES 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral ★** M 2□ F MAY 3, 1921 ITALY Director 579-18-0045 83 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location ral', or items 23a or 28a-f ahov Examiner must be notified at 1 Yes 2 □ No PRINCE GEORGES TEMPLE HILLS Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20748 6751 ALLENTOWN RD. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours atter anent of Health and Mental Hygiene. and It item 27 is marked other than "natural", or ite ury or othar traumatic evant, the Medical Extrinities 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: Specify: þ 3 Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **FOREMAN** SAFEWAY ICE CREAM 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Peges 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic as **ERNESTO** CONSORTT MARIA ANTONIO D'ORIZIO 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA C. CHAMBERS/DAUGHTER 5051 TEMPLE HILL RD., TEMPLE HILLS, MD. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donetion 5 ☐ Other (Specify) b RESURRECTION CEMETERY 4-1-2005 CLINTON, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A hanbeus 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Pert1. Enter the disease, or complications in at ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE **YEARS** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medicai the as use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Pe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2X No Hospitel or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ٢ 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After ! 1 Natural 2 Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours. To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D19431 MARCH 28, 2005 9+1 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe FRANK M. RYAN, M.D. 11701 LIVINGSTON RD., #103, FT. WASHINGTON, MD.20744 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 30 Registrar

Amended Items 10e,10g,19b per F.D. 04/01/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Control Processing Control				For State Registrar	State of Maryla		artment of H		-	giene Reg. No.	005	12556
Examiner Secular Security Process Securi		•		W A . 1	01/10/					Day		
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Top State Top Company				215-15-5372					s. 8. Date of Bird (Month, Da May 3,	th y, Year) 1974	Cour	itry)
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Physician Micelean Physician Physici	nore,	ages 1 a nt of Hea t: If item y or othe		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation	20b 3 □Removal from State	cemetery, cre	osition (Name of matory or other place	e)	Date			
Physician // Medical Examiner	Baltir	permit. P Departme Importan any injur.				Bu	2. Name and Addres	ss of Facility en Funer	cal Home	and C	remator	ry, P.A.
Physician // Medical Examiner The decidal E				23a. Part1. Enter the disease, or	complications that caused the de						1d MD 2	Approximate
Soluminate to the control of the con				Immediate Cause (Final disease or condition	_a Acuter		enous leuk	emia				
The first interest of the second property of	L		_	Sequentially list conditions,	b. Bone m.	arrow	allue					
Potential Control of State Potential Cont		and transit	amine	that initiated events	· Preumo	nia						
The past 12 months? If FEMALE: 23b. Was decedent pregnant in the past 12 months? In the past 12 mon	3760,	ite be ex iysician a he burial	ical	. Cooking in Cookin, Zuck	d	equence or):						
25. Was case referred to medical examiner? 1 Yes 25 No Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural 5 Pending investigation 5 State 24 Death 1 Matural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury	9	ntifica ng ph s as th	ed	IE EEMALE:								
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The state of the s	tal			25. Was case referred to medical				26. Place of De			1 1 105	ZIZ NO
2 Accident 3 Suicide 4 Homicide 5 Building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office 2 City or Town, State) 29a. Certifier (Check only one) 2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title officeritier 29c. License number P 1 766 8 3 25 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. HUNH 22 SAITH GIVENEST BALTIMOVE, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	>	ysicia s cer direct			Hospital:	☐ ER/Outpatie	nt 3 DOA Oth	or.			Other (Specifi	v)
building, etc. (Specify) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. HUNH 22 SATH GIVENEST, BALTIMONE, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ion of	nding Phy th. : After thi e funeral o		1 Natural 5 Pending	28a. Date of Injury (Month, Day Year		of 28c. Injun World	y at k?				
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. HUYNH 22 SOUTH GIVENEST, BALTIMONE, MD 21201 31. Date filled (Month, Day, Year) 32. Registrar's Signature	Divis	al or Atte s after des I Directo d in by th	ertifica	determin	ned 286. Place of injury - A	t home, farm, st ecify)	reet, factory, office				Number or Rura	l Route Number,
WILT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. HUYNH 22 SOUTH GIVENE ST BALTIMOVE, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ne Hospit n 24 hours ne Funera		(Check only 2 [] Medical E	xaminer: On the basis of exam	knowledge, dea ination and/or ir	th occurred at the tin	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) ar date and pl	id manner as st ace, and due to	tated. the cause(s)
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Julie		10-64		30. Name and address of person v	who completed cause of death (I	tem 23a) (Type ST BA	Print)	10 2120	1			
							South .					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 22 2005 0109 Baby Girl Chowdhury <u>March</u> /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery

9. Birthplace (State or Foreign Country) Holy Cross Hospital Silver Spring
II Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1□M 2QF Hours 0 None March 21,2005 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 IISA 1121 University Blvd, W. #1107 death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or its ury or other traumatic event, the Wolffal Exutrical 1 ☐ Yes 2 ☐ No If Yes, Give 12 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bratati Basu Bhabadeb Chowdhury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 1121 University Blvd, W. #1107, Silver Spring, MD Bhabadeb Chowdhury/ Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 26, 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Gate of Heaven Cemetery 2005 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. KenSkille 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** Pulmonary Hypoplasia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Prematurity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a conescuarios of) Examiner 8 Weeks The law requires that the death certificate be executed for use as the burial-transit Preterm Rupture of Membranes Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 X No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. been signe should be Hypovolemic Shock 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 2X No certificate 1 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: N☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2X No 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 5 Pending investigation Injun 1X Natural 1 ☐ Yes 2 ☐ No death. after death | Director: / d in by the f 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/22/05 D 50522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Picard, M.D. 1500 Forest Glen Road Silver Spring, Maryland 32. Signature 31. Date liled (Month Day, State 2005 9 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15

Certificate of Death

			For State	State of Maryl		artment of H tificate of I			gienen () 5 Reg. No.	12558
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia		Guy Francis Carbis					Month March 2	Day Ye	12:05am ^M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	r Location of Dea	_	4c. County of E	
	Examin	er	Wilson Health Care			Gaither	shure		Montgon	nerv
	Funeral		5. Social Security Number 6. Sex	7. Age (In)	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		h 9.	Birthplace (State or Foreign Country)
	Director		552-05-2064	M 2□F 8	9 Yrs.	Months Days	Hours Min	March 1		Colorado
	p		Usual Residence of Decedent		0': T					40d Inside City I faite
	show	_	10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits 1 AYes 2 No
	e Ma	cto	Maryland Montgomer	y I	Rockvill					
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
	ath w		14431 Traville Gar			20850	C		United St	ates American Indian,
	ar da terms	Funeral	11. Waltar States	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (; an, Mexican, Puei	specify Yes or No- rto Rican, etc.)	Black, V	Vhite, etc.
36	within 72 hours after death with the Maryland ene. Then "naturel", or liems 23a or 28a-f show Its Modical Examinar must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2]② No	Specify:		Specify:	White
215-0036	hour ture	ba	15. Decedent's Educ		16a, Dece	dent's Usual Occup	ation	1	16b. Kind of Busin	
ن	in 72	ojet	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most of wo	orking		,
212	with lene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Produc	ction Sup	ervisor		Busines	s Forms
b	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)			•		me (First, Middle,	Maiden Sumame)	
al	Id benta ked ked ic ev	To B	William Carbis				Pearl N	Nichols		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 27 is marked other then. "naturel; or liems 23a or 28a-f show mortion: If item 27 is marked other then." alturel; or liems 23a or 28a-f show my injury or other treumatic event, the Model Examiner mat be notified at once.		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailir	ng Address (Street	and Number or F	lural Route Numbe	er, City or Town, Sta	te, Zip Code)
Ž	is 1 and 2 of Health a item 27 is other tree		Marie Catherine Ca					ns Circle	, Rockvil	le, MD 20850
Baltimore,	of He item		20a. Method of Disposition	20	b. Place of Dispo cemetery, crei	sition (Name of natory or other place	ce)	Date	20c. Location - City	y or Town, State
Ĕ	Page Thent of		1 ☐ Burial 2 ∰Cremation 3 ☐R '4 ☐ Donation 5 ☐ Other (Specify)	novarirom State	Metropol:	itan Crem	natory 3	3/25/05	Alexandri	la, Virginia
a E	Departi Departi Importe eny inju		21. Signature of Funeral Service License	ss of Facility De	Vol Fune	ral Home				
m	88 = 8		Volent His	Pol	Ġ.) East De aithersbu	irg, MD 2	284776		
			23a. Part1. Enter the disease, or compli	cations that caused the cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between
	Enysician .		Immediate Cause (Final disease or condition	Rissi	rata	u fa	ilus	2		Onset and Death
	/Medical		resulting in death)	Due to (r as a cor	nsequence of):	10				
	Examiner		Sequentially list conditions	Ineu	mi	nia				
	p #	lner	Sequentially list conditions, large leading to immediate cause. Enter Underlying	Due to or as a cor	nsequence of):	struc	8 -110	h - , O m	221111	
	and trans	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	anon		me	rever	di	street	
, 0	icate be executed physician and s the burial-transit	ũ	resulting in country cast	Due to (or as a cor	isequence or):					
38760,	ate b	dicai								
~		(1)	IF FEMALE:	3c. If yes, outcome of pr	2002004			100.	004 D-4	4.4-15
Вох	death certific e attending p ed for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnancy	у		23d. Date of Month	Day Year
o.	0 0 0	Physiclan/Mo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	ordeath 3L	Other (specify) _				
<u>a</u>	The law requires that the de ate has been signed by the a bage 2 should be detached t		Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
Records,	sign d be	1 by	Cachesia	Dune				121	/ Yes 2□No 3[Probably 4 Unknown
Ö	w require been si should b	Completed	Esmhagane	willing	,			24a. Was	an 24h Wer	e autopsy findings available
ec.	has has	mpi	progene	7				autop	osy prior deat	r to completion of cause of the
								1 Tes	202 No 1	Yes 2□ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:	- C = 2 to	Ott	or /	eath (Check only o		
ot	Phys this ral di	٦.	1 Yes 2 No	28a. Date of Injury	2 ER/Outpaties 28b. Time o	IT 3 DOA	4 Friursing	_	dence 6 Other (Specity)
no	ding P h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month, Day Yea	ar) Injury	Wo	rk? Yes 2 □ No		. ,	
Division	or Attending after death. Director: Afte in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, st	reet, factory, office		28f. Location (5	Street and Number o	or Rural Route Number,
Ω	or Attendate death after death I Director: /	Certification:	4 Homicide	building, etc. (S	pecify)			City or Tov	vn, State)	
	spite lours nere!		29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge, deat	h occurred at the ti	me, date and plac	ce, and due to the	cause(s) and manne	er as stated.
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical	(Check only 2 Medical Exeminate)	ner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my o	opinion, death occ	curred at the time,	date and place, and	due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier		1	29c. Licens			29d. Date signed (A	
			1/4/sheet	moch	has he	11 10	4125		March	25,2005
	19		30. Name and address of person who co	mpleted cause of death	(Item 23a) Type,	Print) 20/	RUSSE	SLLAU	ENLLE	2 0 00
	12		ISIKOBERT B	1KSCHBAL	ett sel	11 6A	17450	SBUK	6 411	200 11)

DHMH 17 Rev 1/2001

State Registrar

Physi	cian	Amend Items 23 1. Decedent's Name (First, Middle, I	Last)	•		ificate of	Death 2	2. Date of D Month	Reg. No	05 Year	2555 3. Time of Death
/Med	lical	Marity		Curti	5			63	24	2005	0830/1
Exam	iner	4a. Facility Name (If not institution, g Clinton Nursir	ng and Reh	abilita	ation (Center	Clinto	or Location of Dea		y of Death CE GeC	orges
Funera Directo		5. Social Security Number 218–30–3789		Age (In yrs. las 88	st birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B. (Month, D. March	irth ay () () () () () () () () () (9. Birthpla Count Maryl	
e Maryland a-f show lifted at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (Georges	10c. City,	Town or Loca	ition lboro				10	od. Inside City Limits 1X Yes 2 ☐ No
h with the 23a or 28	Funeral Director	10e. Street and Number 12009 Windsor Ma	anor Road	<u> </u>		10f. Zip Code 20772			10g. Citizen of USA	What Count	ry?
5-UUZU 72 hours after death with the Maryland 72 hours after death with the Maryland natural, or items 23e or 28e-f show ifeel Evand et must be notified at	र्व	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	s?] No	II Y	as Decedent of H es, specify Cub	fispanic Origin' an, Mexican, Pi Specify:	? (Specify Yes or Nuerto Rican, etc.)	o- 14. Ra	ce - America ck, White, e	itc.
within ene.	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4o	r 5+)	16a. Deceder (Give kir life. DC Homem	nt's Usual Occup od of work done NOT use retired aker	nation during most of d)	working	16b. Kind of B		ıstry
yidild A build be filed Mental Hygie arked other i	To Be C	17. Father's Name (First, Middle, Las Charles	Devi	.lle			18. Mother's	Name (First, Middle Anr		_{пө)} ell	
e, Malyld Tand 2 should I Health and Men em 27 is marked wither treumatic		19a. Informant's Name/Relationship Edward Curtis /	(Type, Print) Son		19b. Mailing 12009	Address (Street Windsor	and Number of Manor	Rural Route Numb Rd Upper	er, City or Town Marlbor	, State, Zip (20772
Pages ent of ht: If it		20a. Method of Disposition 1√□ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		e cem		ion (Name of fory or other place on Ceme		Date 3/30/05	20c. Location	_	
permit. Pa Departmen Important: eny Injury		21. Signature of Funeral Service Lice	onsee	-	22. N	lame and Addre	ss of Facility	e P.A. Ad	masco.	Maryla	and
8.1		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that cause							P	Approximate nterval Between
Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	a. COV	Subdur		ationa w	ith con	plication	ns		Donset and Death Anoul
g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resuting in death.) Last	b. 144	Due t (or as	a consequer	n/h	CEF	THE CATION APPROV	ED B1 mm		1 Mont
	Physician/Me		d		Cova	ewit		18/80	cliw)	03 -	1 Mas
v requires that the death cert been signed by the attendin should be deteched for use	by Physi	Hypertension, D		but not resultin	g in the unde	rlying cause give	en in Part I.	23b. Did	_/		he causa of death? bly 4 ☐ Unknowr
or Attending Physicien: The law requires that the death certeffer death certeffer death certificate has been signed by the attendir in by the funeral director, page 2 should be deteched for use	Completed b							24a. Was perfo	an autopsy rmed?	availa	e autopsy findings able prior to pletion of cause ath?
hysicien: The law his certificete has t il director, page 2 s								101	res 2⊠No	1 □ Y	Yes 2□ No
Attending Physicien: r death. ector: After this certificaby the funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ient 2 🗆 EB	Outpatient	3□ DOA Othe		leath <i>(Check only o</i> Home 5□Resid		40 14 1	
g Phy erthi		27. Manaér of Death	28a. Date of Inju	ury 281	o. Time of	28c. Injury Work			now injury occurr		
endin eath. or: Af	atic	1 € Natural 5 Pending investigation	02/14/2		7:35 a		res 20 No	Subject	fell		
To the Hospital or Attending Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral dis	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	nursing	home				CITITO	Street and Numb vn, State) 921 1 Nursi n	g & Ke	enab,_
Hosp 24 hou Funei stely fil	edical	29a. Certifier (Check only one) 1 ✓ Cartifying Ph 2 ☐ Medical Exam	nysician: To the best minar: On the basis o and manner st	of examination	lge, death oc and/or invest	curred at the tim igation, in my op	e, date and pla inion, death oc	ce, and due to the c curred at the time,	cause(s) and ma date and place, a	nner as state and due to th	on, MD ne cause(s)
To the within 2 To the сотрlе	Me	29b. Signature and title of certifier	and manner st	ated.	<u>_</u>	29c. License	number		29d. Date signed	i (Month, Day	y, Year)
		1/V	W	7 M	2)-	245	35	03,2	5,0	5
355		30. Name and address of person who Laxmi Berwa MD 7°				t) C-101	Clinton	,Maryland	20735		-
	te	31. Date filed (Month, Day, Year) MAR 2 9	2005 32. Registr	rar's Signature	4 L	ale					

DHMH 16 Rev 6/95

			1 - For State Registrer	State	of Marylai	nd / Depa	artment of	f Health a of Death		Re	g. No.)5	12560
	Dhusisi		1. Decedent's Name (First, Middle						2	. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medio		Marguerite Ca	rter					M	arch 24	, 2005		13:46 рм
	Examir		4a. Facility Name (If not institution	•	u <i>mber)</i>		4b. City, Town	n, or Location o	of Death		4c. County	of Death	
			Holy Cross Hos					Spring	g		Monte	ome	ry
ш	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F		. last birthday) 33 Yrs.	If Under 1 Ye Months Da		Min.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign intry) hington, DC
	Director		579-34-7507 Usual Residence of Decedent) / ris.			A	ugust 3	0,1921	Was	hington,DC
1	* H		10a. State 10b. County		10c. C	ity, Town or Lo	cation			·			10d. Inside City Limits
	-f sh	ō	MD Prince	e Georges	т.	emple H	ille						1∑Yes 2 No
4	280	Jec.	10e. Street and Number			ompic ii	10f. Zip Cod	le		10	g. Citizen of W	/hat Cou	intry?
1	36 0	Funerai Director	4203 Hargrove 1	Rd.			207	47			USA		
9	ms 2	ner	11. Marital Status		cedent Ever in l	J.S. 13.1	Was Decedent of If Yes, specify C	of Hispanic Ori	igin? (Speci	fy Yes or No-	14. Race		ican Indian,
9	or Ita	Ē	1 Never Married 2 Marri	Amed F ed 1 Tes If Yes, G	2 🔀 No		irres, speciny ∪ 1 □ Yes 21∑l			can, etc.)		k, White	
ဥ	e je	d by	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:		10 105 2,411	чо зресну.			Specify.	BT	ack
2	"nett	Completed	15. Decedent (Specify only highes)	16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use rei	cupation ne during mos	t of working	, 1	6b. Kind of Bu	siness/Ir	ndustry
2	han han	ш	Elementary/Secondary (0-12) 9th	College	(1-4or 5+)			tired)			Gover	nman	+
2	Hygie thar I		17. Father's Name (First, Middle, I	ast)		Clia.	irwoman	18 Mothe	ar's Name /	First Middle M	faiden Sumam		
and	ed of	Be	Benjamin Branc	,					a Pry		alderi Samam	"	
Maryland 21215-0036	and and a should be med within 72 mous and occur with the way and the either and Mental Hygiene. It Health and Sa or 28e-1 show then 27 is marked other than "neturel", or Itams 23e or 28e-1 show other traumatic event, the Medical Evan's at most be notified at	T ₀	19a. Informant's Name/Relationsh			19h Mailir	ng Address (Stre				City or Town	State 7i	n Code)
40	ith an		Patricia Jeffe		uchtor		Natahala					, , , , , , , , , , , , , , , , , , ,	p 0000)
a	of Health item 27 I		20a. Method of Disposition	ISON/ Da	20b.	Place of Dispo	sition (Name of		Dat		20735 Oc. Location - 0	City or T	own, State
ou Ou	t: Hill		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		n State	-	natory or other i		02/20	/000F T			
Baltimore,	Department of H Importent: If ite eny injury or ot	- 1	21. Signature of Funeral Service	1	110	22	. Name and Ad	Idress of Facilit	U3/28/ w.T. B	ZUU5 I	Funo:	oa,	Maryland
ä	Depa Impo eny ir			3		74	474 Land	dover R	d., L	andover	, MD 2	2078.	
	- "		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not ent	er the mode of	dying, such as	cardiac or r	espiratory arre	st,	7	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition		ngestive	Uoont	Trad 1	_					Onset and Death
	/Medical		resulting in death)		o (or as a conse		rallur	е					
	xaminer		Sequentially list conditions	b. Ch	ronic Re	enal Fa	ilure						
7	2 =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to	o (or as a conse	quence of):							
-	and -trans	саш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a conse	guana of):						_	
760,	hysician and the burial-transit	ical E	• • • • • • • • • • • • • • • • • • • •	Due it	Ol as a conse	quence on.							
687	The far requires that the death centilizate for account to the has bash signed by the attending physician and bage 2 should be detached for use as the burial-transit			d.			-						
X	attending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregn	ancy					23d. Date	of deliv	env
Вох	atter d for u	ciar	in the past 12 months? 1 ☐ Yes 2 ☒ No		birth 2 Fet		Ectopic pregna Other (specify)				Mon		Day Year
о. С	by the a	Physician/Med	9 Unknown	9□ Unk	nown					,			
T.	igned be det	ру Р	Part II. Dther significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use contri	bute to f	the cause of death?
Ö	baan sig	ed	Diabetes Melli	tus	·					1 🗌 Ye	s 2 🗆 No	3 🗌 Prol	bably 4 □Unknown
Records,	has bange 2 sho	plet	Hypothyroidism							24a. Was an	24b. W	/ere auto	opsy findings available ompletion of cause of
ř		Completed								perform	ed? d	eath?	2 No
ita	certificate	Be (25. Was case referred to medical examiner?							Check only one)		
> 1	this co	2	1 ☐ Yes 2 ☒ No			ER/Outpatien	t 3 DOA	Other: 4 ☐ Nu	ırsing Home	5 🗆 Resider	nce 6 Othe	r (Speci	fy)
0 2	r death. sctor: After this certification of the funeral director.	ë.	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	28c. Ir	njury at Work?	286		w injury occurre		
Sio	tor: A	cati	2 Accident investig	ation ot be				Yes 2 1					
= 1	in Line	ertification;	4 Homicide determi	ned 200. Pide	ce of Injury - At It ding, etc. (Speci	nome, tarm, str ify)	eet, factory, offi	Ce	281	City or Town,		r or Run	al Route Number,
<u>ا</u>	Funeral E	0	29a, Certifier 1X Certifyin	g Physician: To th	a heet of my kn	owledge death	a consumed at the	a time date an	d place, and	d due to the oc	uso/s) and mas		stated
3	within 24 hours affe To the Funeral Dir completely filled in	Medical		xaminer: On the									
4	within 2 To the complet	Me	29b. Signature and title of certifier	1			29c. Lice	ense number		29	d. Date signed	(Month,	Day, Year)
,	, ~ 0		1/	1-	_	WD.	Da	045/2	2/	1	3/24/2	005	_
0	To		30. Name and address of person v	who completed car	use of death (Ite	m 23a) (Type,	Print)			OP.	3/24/2 14:54	1	Λ
	9		30. Name and address of person of BRIAN F. R	JAC AN	Ka	المحب	01/10	c F	th (CK027	14.21	orte	3 \
	Sta		31. Date filed (Month, Day, Year) MAR 2 9 2	105	Registrar's Sign	ature	w .		J				
	Registr	ar	MAK & J &	100	SHU N	A							

			1 - For State Registrar	State of Ma	aryland		artment of H		Mental Hy	giene	2005	I was some you
			Decedent's Name (First, Middle, Last	')					2. Date of De		-440	3. Time of Death
	Physicia		Franklin	Duane	Cas	÷			March	28. Day	2005 Year	7:50 P _M
	/Medic Examin		4a. Facility Name (If not institution, give			<u> </u>	4b. City, Town, or	Location of Death			County of Death	7.50
	LAGIIIII	٠,	26591 Nanticoke	Road			Salisb	111277			Wicomic	10
	Funeral				e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth Year)	9. Birth	place (State or Foreign
	Director		444-26-7827	ĴM 2□F -	75	Yrs.	Months Days	Hours Min.	5/28/	1929	Okla	ahoma
	pu >		Usual Residence of Decedent 10a. State 10b. County		10= Cit.	Town and a						
	anyla shov	7	Maryland Wicomic	' O		Town or Lo lisbu						10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	Director		.0	Da							
	with 1		10e. Street and Number 26591 Nanticoke F	beo!			10f. Zip Code 21801				en of What Cou	ntry?
	eath	Funeral	11. Marital Status	12. Was Decedent B	Ever in IIS	12.1	Was Decedent of Hi	coania Origin? /So	anifu Van as N	US	4. Race - Ameri	an Indian
	iter d	Lun	1 Never Married 2 Married	Armed Forces?			f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	, '	Black, White,	
336	urs al	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 2MiNo	Specify:			Specify: whi	ite
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		15. Decedent's Edi			16a. Deced	dent's Usual Occupa	ation		16b. Kin	d of Business/In	dustry
215	hin 7	Completed	(Specify only highest grad	de completed) College (1-4or 5	i+)	(Give life. I	kind of work done of DO NOT use retired,	furing most of work)	ing			
7	giene giene	NO.	12	3	9	Quali	ty Contro	l Engine	er	Ae	ros p ace	
밀	al Hy t oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle	, Maiden S	Surname)	
Vla	Ment Rarkec	To	Olin J. Cast					Laura	Henrie	tta M	cAllist	er
lan	2 sho and is mu		19a. Informant's Name/Relationship (T)	•		19b. Mailir	ng Address (Street a	and Number or Run	al Route Numb	er, City or	Town, State, Zij	Code)
2	and ealth m 27 ner tr		helen I. Cast/wif	e		2659	Ol Nantic	oke Rd.,	Salisb			
ore	of H of H if iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ I	Removal from State	20b. Plac	ce of Dispo netery, cren	sition (Name of natory or other place	e)	Date	20c. Loc	ation - City or To	own, State
Ĕ	Pag ment ant:		* 4 ☐ Donation 5 ☐ Other (Specify,		Firs	st Bar	otist Cem	. 3/31	./2005	Poc	omoke C	ity, MD
ä	permit. Depart Import sny inj		21. Signature of Fundral Service Licens	ee		22 F	Name and Address	s of Facility Melson Fu	neral i	Home,	РΔ	
_	70 E 29		Muchael AL	Sean			l03 Linđe	n Ave., F	ocomok	Cit	y, MD 2.	1851
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	ications that caused ne cause on each lir	the death. ne.	Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a	Brain	Can	ce					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):						**************************************
В	LAGITITIES			b	lung	C14	nu					
	sit sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):						
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a conseque	nce of):						
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burfat-transit	al E		200 (0) (0)	a 90,100qu0							
687	icate phys s the	dlcal		d								
	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnanc	ev .				20	d Data of dollar	
Вох	eath atter for u	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal d	éath 3 🗀	Ectopic pregnancy Other (specify)			23	3d. Date of delive Month	Day Year
o.	that the de led by the a detached t	iysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown								
<u>a</u>	res that igned b be deta	by Pt	Part II. Other significant conditions co	ntributing to death bu	ut not resulti	ing in the ur	nderlying cause give	n in Part I.	23e. Did	obacco us	e contribute to t	ne cause of death?
rds	puires n sign								1 🗆	Yes 2	No 3 □ Prot	ably 4 Donknown
- O	w requir been si should	lete							24a. Was	an	24b. Were auto	nsy findings available
Records,	he tay e has age 2	Completed							auto perfe	psy ormed?	death?	psy findings available mpletion of cause of
Vital			25. Was case referred to medical					26. Place of Deati	1 Yes	21 110	1 🗌 Yəs	2 No
>		o Be	examiner?	Hospital:	nt 2 EF	R/Outnatien	t 3 DOA Othe			-	☐Other (Specif	
Division of	를 부 를	-	27. Manner of Death	28a. Date of Injur	ry 2	8b. Time of	28c. Injury	at	28d. Describe			97
<u>o</u>	Attending r death. sctor: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day	7 1007)	Injury	Work M 1 □ Y	es 2 □No				
Vis	I or Attending after death. Director: After I in by the funer	ific	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At hom	e, farm, str	eet, factory, office		28f. Location (City or To	Street and	Number or Rura	l Route Number,
Ō	tel or A s after el Direc ed in by	Certification;	- I 101110100	building, etc	. (Specify)				Only of 10	mi, oldle)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier (Check only 2 Medical Exami	sician: To the best of	of my knowle	edge, death	occurred at the tim	e, date and place,	and due to the	cause(s) a	nd manner as s	tated.
	the H in 24 the F iplete	Medical	one)	and manner sta	ited.	n anwor m		death occurr	ed at the time,	dato and p	nace, and due to	o the cause(s)
	To the within To the comple	2	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month,	Dey, Year)
			> huth	,			Hoo	5619)	3/2	5/05	
1-	16		30. Name and address of person who co									
	-01		Robert Coker, 2 31. Date filed (Month, Day, Year)					oury, MI	2180 כ	1		
	Sta Registra		MAR 3 1 20	32. egistra	- 1	x Ag	rade					

			1 - For State Registrar	State of Maryla		artment of H			iene	12562
	Physici /Medi		Decedent's Name (First, Middle, Las FRANC	S LEE CUTA	IR 3r	-d		2. Date of Death		3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give	lursing He	ome		Location of Deat Location of Deat	ce	4c. County of Dea	
	the Maryland 28a-f show	5	Usual Residence of Decedent 10a. State 10b. County MD Harford		ity, Town or Lo			J/ 1 1/ 1 2	,30 Ha1	10d. Inside City Limits
	death with the Maryland ims 23s or 28s-f show r reat be neithed at	I Director	10e. Street and Number 1994 Castle			10f. Zip Code 210	134	10	g. Citizen of What Co	1 ☐ Yes 24 14 No puntry?
036	iges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygenes. If item 27 is marked other than "natureli, or items 23s or 28s-4 show or other traumatic event, it is Modical Exit, direct maske a callified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes XIXNo If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 【 Ko		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Baltimore, Maryland 21215-0036	e filad within 72 hours aftar at Hygiene. othar than "natural", or ita vent, I're Medical Exertifie	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	ation furing most of wor)	king	6b. Kind of Business	,
yland;	should be filad nd Mental Hygi marked othar Imatic evant, I	To Be C	17. Father's Name (First, Middle, Last) Francis Lee Cut	air Jr.			Doris	ne (First, Middle, M Atkinso	aiden Sumame) On	
ore, Maı	ges 1 and 2 sho it of Health and if item 27 is m or other traum		19a. Informant's Name/Relationship (T. Josephine E. Cu 20a. Method of Disposition 1 □ Burial 2 □ Qemation 3 □ I	tair - wife	Place of Dispos	g Address (Street a Castle sition (Name of patory or other place	ton Rd.	Darling	City or Town, State, 2 ton, MD 2 Oc. Location - City or	21034
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Records, P	w requiras that been signed t should be deta	þ	Part II. Other significant conditions con		ulting in the un		n in Part I.		cco use contribute to	the cause of death?
		e Completed	25. Was case referred to medical						prior to co	opsy findings available ompletion of cause of
ō	ding Phys h. After this funeral di	5 B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 Inpat	ER/Outpatient 28b. Time of Injury	3 □ DOA Other 28c. Injury a Work?	" 4 Nursing Ho	th (Check only one) The S Residence 28d. Describe how	ce 6 □Other (Speci injury occurred	ify)
DIVISION		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	v) 			City or Town, S		
	To tha Hospital within 24 hours a To tha Funeral I completely fillad	Medical	29a. Certifier (Check only one) 2□ Medical Examination 29b. Signature and title of certifier	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inve	estigation, in my opi	nion, death occur	ed at the time, date	se(s) and manner as a and place, and due to be a be a signed (Month,	to the cause(s)
	- s - 0		30. Name and address of person who ca	form MD mpleted cause of death (Item	23a) (Type, P	0453			4/06/20 E, MO 2	,
	State		SURESH DHAN JA 31. Date filed (Month, Day, Year) APR 1 3 200	3 Registrar's Signa	S. ON	ON AVE	HAVRE	DE GRAC	E, MOZ	1078

			State of Maryland / Departme 1- State Unpend Item 23a,27,28a-f per me G843 Certifica	nt of Health and N 5-12-05, tas te of Death	Mental Hyg	giene leg. No: 005	12563
	Physici		Decedent's Name (First, Middle, Last) Douglas Wayne Caricofe		2. Date of Dea Month APRIL	Day 2005	3. Time of Death 4:03 P. M
	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City	r, Town, or Location of Death		4c. County of Deet HARFORD	
2451	Funeral Director		215-86-3143 1∑ M 2□F 41 Yrs. Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day Mar. 25	r, Year) Co	hplace (State or Foreign untry) yland
- /	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	he Mar 8a-f si	Director	Maryland Harford Abingdon				1 ☐ Yes 2 🗖 No
	a or 2	Dir		ip Code 1009	1	10g. Citizen of What Co USA	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or othar traumatic event, If a Medical Evaniner must be notified at once.	by Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, White	
Maryland 21215-0036	72 hou natura	eted I	15. Decedent's Education 16a. Decedent's Usi	Jal Occupation	kina	16b. Kind of Business/	Industry
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nd 2	al Hygi al Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam		Constructi Maiden Sumame)	On
yaı	d Ments d Ments narked natic e	To	Donald Lee Caricofe	Gloria			
	nd 2 st alth and 27 is n	li i		is (Street and Number or Rui ie Lane, Fore			
Baltimore,	of Head of Item	li	20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Na cemetery, crematory or cemetery, crematory or cemetery).	ime of other place)	Date	20c. Location - City or	Town, State
ij	it. Pag tritment ritant: njury c		`4 ☐Donation 5 □ Other (Specify) Bel Air Mem.G	ardens Apri		5 Bel Air	
Ba	Departing Department of the policy of the po			Cokesbury Ro			•
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cocaine Intoxication	de of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
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Vital Records, P.O.	The taw requate has been page 2 should	Completed			24a. Was a autops perform	24b. Were au prior to death?	topsy findings available completion of cause of
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Divis	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify) Found at home	y, office	28f. Location (St. City or Town Abingdon	treet and Number or Run, State) 4023 Ab	ral Route Number,
	24 hou Funer stely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred a Clerk only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	dat the time, date and place, n, in my opinion, death occur	and due to the carred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within To the comple	Me		9c. License number	2:	9d. Date signed (Month	o, Day, Year)
			Mayite Brethell my	OCME	A	PRIL 9,2005)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARGOMO DICOREU 1111F	PENN STREET, I	BALTIMORI	E. MARYLAND	21201
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2005			,	

		1 - State Registrar	State of Marylan	•	artment of H			gieņe Rag. No. 00	5 12561	-
0		Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Deat	h
Physici /Medi		CARLOTT	A MAR	Y	CROCKE	R	ADMI		2005 08:40	Рм
Examir		4a. Facility Name (If not institution, give st. Sirai HOSP ital 8		2		r Location of Death	ity	4c. County	of Death	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	Birthplace (State or Fore Country)	əign
Director		215-28-4970	M 3 7 □ F 77	Yrs.			5/13/	1927	Maryland	
land		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Lin	nits
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with the Maryland a or 28e-1 show the rediffed at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	_
ath wit	aiD	4036 Stansbur	y Mill Roa	d		21111		Unite	ed States	
ter des Items	Funeral	TI. Waltan Grade	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.	
# PE	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		1 □ Yes 2 X No	Specify:		Specify	White	
"natural",		15. Decedent's Educa	ation	16a. Deced	dent's Usual Occup	ation		16b. Kind of Bu	usiness/Industry	
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artme artme ortant injury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses		rnon	Cemeter Name and Addre				Hall, Md.	
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tha H in 24 tha F nplete	fedical	one)	and manner stated.							
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100		Julianell	encior. Piv		KO.	7-000		כ ויעעיק	, 2005	
100		30. Name and address of person who con	npleted cause of death (Item	1 23a) (Type,	Print) i Hysspitz	el of Ba	ltimor	e		
Sta	at <u>e</u>	30. Name and address of person who con J Ulian ne ken to APR 1 2 2005	2. Registrar's Signa	ture	. 071.10	- 700				_
Regist	rar	APR 1 2 2005	Bleen D.	A con	Cr)					

hysici	an	Decedent's Name (First, Middle, Las	st)					. Date of Death Month	Day	Year	3. Time of t
/Medic		Dorothy E. Doran						APRIL	07, 2	005	2:12p
xamin	er	4a. Facility Name (If not institution, give	street and number))	4b. City, Towr	n, or Location	of Death		4c. County		
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5 2	to	Maryland Montgom	erv	Whe	aton						1 Tes 2
and and	Director	10e. Street and Number	.cry	WIIC	10f. Zip Code	θ		10	g. Citizen of V	Vhat Cou	intry?
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SEC.	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	B. Was Decedent of If Yes, specify C	of Hispanic Ori Juban, Mexicar	igin? (Specif	y Yes or No- can, etc.)		e - Ameri k, White,	ican Indian, etc.
or i	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 □ Yes 2 🔀 If Yes, Give	No	1□Yes 2₺N				Specify		
Tural al Ex	ed b	15. Decedent's Ed	Year or Dates:	16a Dec	edent's Usual Occ	cupation		1.4	6b. Kind of Bu		nite
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	sician edical		ownes				Month		Year 003	5 M
	miner	4a. Facility Name (If not institution, give			1	or Location of Death		4c. County		
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Fune: Direct			MM 2DE	95 Yrs. (ast birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Sept. 28		9. Birthplace (State o Country) Maryland	r Foreign
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State Registrar

MAR 3 0 2005

			For State	State of Maryla	•	artment of H		Mental Hy	- 1	11115	12567
			Registrar 1. Decedent's Name (First, Middle, I	.ast)		tineate of L	Jean	2. Date of De	Reg. No.	. 0 0 0	3. Time of Death
	Physici		Barbara R. Duff	(March	26	2005	12:40 PM
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Dea			County of Dea	
			441 Wilson Road	d		Risina	Sun			Cecil	
	Funeral			Sex 7. Age (In yr:	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir). (Month, Di	rth ay, Year)	9. Bir	thplace (State or Foreign
	Director		219-58-1667 Usual Residence of Decedent	7.	54 Yrs.			Novemb	er 6	,1950	MD
	/land		10a. State 10b. County	10c. C	City, Town or Lo	cation					10d. Inside City Limits
	Man B-f st	tor	MD Ced	cil F	Rising.	Sun					1 □ Yes 2X No
	or 280	irec	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	ountry?
	23a	Funeral Director	441 Wilson Road	(21911			U.	S.A.	
	er der teme	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes or No irto Rican, etc.)	0-	 Race - Ame Black, Whit 	
36	rs aft	oy F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	I 1 ☐ Yes 2 █️No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			Specify: Wh.	ite
Ş	within 72 hours after deeth with the Maryland ene. then 'naturel', or iteme 23e or 28e-f show the Modical Everificat natal be notified at	Completed by	15. Decedent's	Education	16a. Dece	dent's Usual Occupa	tion		16b. Ki	ind of Business	/Industry
215	hin 7.	pie	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired)	uring most of w	orking			
2	ed wil	Con		4	Tead	cher			Put	olic Sch	rools
nd	be file id oth	Be	17. Father's Name (First, Middle, La.					ame (First, Middle		Sumame)	
Z	should be and Mental markad o	P	Robert Rawlings 19a. Informant's Name/Relationship		10h Maili	- Add (Ch		ice Bidd		. T	7. 0. /)
Ma	d 2 sl th an th an treur		Ryan C. Duff/So			ng Address (Street a					zip Code)
ō,	Heel Heel tem 2		20a. Method of Disposition		Place of Dispo	Wilson Ro sition (Name of natory or other place		Date		cation - City or	Town, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department if fiem 27 is marked other then "natural", or iteme 23e or 28e-f show any injury or other treumatic event, ite Madical Evantral fortal be notified at ance.		1 ☐ Burial 2 💢 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	- nemoval nom state			10 3 - 2	29-2005	2011	C	Un
Ħ	permit. P Departm Importer any injur		21. Signature of Funeral Service Lic	110	22	d Funeral Name and Address	s of Facility R	T. Foate	I FILE	ng Sun,	imo D A
ä	Depa Impo any ir		Kuchand X	Goodie	11	1 S. Quee	n Stree	et. Risin	ia Su	in. MD	21911
			23a. Parri. Enter the disease, or co shock, or heart failure. List on	mplion are that caus of the de- ly one or use on each line.							Approximate Interval Between
J.113	Physician		Immediate Cause (Final disease or condition	AMERISCL		CARDIOVIS					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse			0				
h	LXammer	-	Sequentially list conditions,	b. Due to (or as a conse	UBL	mire	VJLMU.	M D	1209	Se	YEARS
18	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence or):						
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9	ng ph as th	Jedi	IF FEMALE.								
Вох	eath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe	tal death 3 □	Ectopic pregnancy			2	23d. Date of del Month	ivery Day Year
Ö.	the all	/sici	1 ☐ Yes 2 🙀 No	4□Pregnant at time of 9□Unknown	death 5	Other (specify)				WORT	Day
P.O.	that the de ed by the detached	Phy	Part II. Other significent conditions	contributing to death but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did 1	tobacco u	se contribute to	the cause of death?
ds,	uires sign			abetts	•	, , , , , , , , , , , , , , , , , , , ,		134	Yes 2[□No 3□Pr	obably 4 Unknown
COL	w require	Completed						24a. Was	an	24h. Were au	itopsy findings available
Re	The lav	ршо		-				auto perfe	psy ormed?	prior to death?	completion of cause of
Vital Records,	iclan: Th certificete rector, pag	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only	2 No	1 🗆 Yes	2 / 0 No
>	nysic nis ce direc	To B	examiner? 1XYes 2□ No	Hospital: 1 ☐ Inpatient 2[☐ ER/Outpatier	t 3 DOA Othe	r	Home 5 Resi		3 □Other (Spec	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury	y occurred	
<u>sio</u>	uttendi death. ctor: A y the fu	cati	1 Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be			es 2 □No	0001			
Division of	i or Attende efter deatl Director: I in by the	Certification:	4 Homicide determine		home, farm, str cify)	eet, factory, office		City or To	Street and wn, State,	d Number or Ru)	ıral Route Number,
	To the Hospitel or Attending Physician: The within 24 hours efter death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying I	Physicien: To the best of my kr	nowledge deat	occurred at the time	e date and plac	and due to the	cause(s)	and mannor as	stated
	e Hori	Medical		aminer: On the basis of examinand manner stated.	nation and/or in	estigation, in my op	inion, death occ	curred at the time,	date and	place, and due	to the cause(s)
	To the Hospitel within 24 hours e To the Funerel I completely filled	Me	29b. Signature and title of gentrier			29c. License			29d. Date	e signed (Mont)	h, Day, Year)
			> WCh	_ ~		D568	11		AM	irch i	26 2005
	10		30. Name and address of person wh	o completed cause of death (Ite	em 23a) (Type,					-11-1	
	1752		***************************************	WIAN MD	nature	1	06 BO	u Stree	et E	EIKtow	11916 dm
	Sta Registr		31. Date filed (Month, Day, Year) NAR 2 9 2	32 Registrar's Sign	iature	e e family					
			MAN 4 9 L	UUU SARAKAN 4	W S						

1	For State of Maryland State Registrar	/ Department of Health and Menta Certificate of Death	2008 10000
Physician /Medical	Decedent's Name (First, Middle, Last) Organical Action (First, Middle, Last) A. Facility Name (If not institution, give street and number)		3 28 2005 16:55 PM
Director	Annistia Regiona Medical Composition of the Social Security Number 6. Sex 1 M 2 DF 7. Age (In yrs. last 25 - 40 - 2595 1 M 2 DF 7)	tt birthday) Yrs. SAIISAUY If Under 1 Year It Under 24 Hrs. 8. Date Months Days Hours Min. Months	e of Birth nth, Day, Year) 9. Birthplace (State or Foreign Country) 15 - 2 7
ylano how		Town or Location 14h ans 10f. Zip Code	10d. Inside City Limits 1 □ Yes 2 No 10g. Citizen of What Country?
5 2 2 5	1. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced 2. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2. No lif Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	s or No- 14. Race - American Indian, Black, White, etc. Specify: R C C
21215-0(ed within 72 hou yejenen "netura nerthan "netura nerthan" netura nerthan "completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LINE - WORKER	16b. Kind of Business/Industry Perdue Poultry
Iore, Maryland ges 1 and 2 should be fit of Health and Mental H if I flam 27 is marked oil or other traumatic even	9a. Informant's Name/Relationship (Type pint)	18. Mother's Name (First, I) 19b. Mailing Address (Street and Number or Rural Route	ropper
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If Itlan 21 any injury or other transme.	Da. Method of Disposition Method of Disposition 20b. Place A Donation 5 Other (Specify) 1. Signature Funeral Service License 1. Signature 1. Signature	22. Name and Address of Facility Reasons	20c. Location - City or Town, State 5 Without, WA 5 Mith Funcial Hom
a a a a a a	23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. mmediate Cause (Final lisease or condition	P.O. BOX23 Withams	VA EXMORE VA
Medical Examiner and I-transit Axaminer	esulting in death) Due to (or as a consequent	Neurona de la constanta de la	
ds, P.O. Box 68760, lires that the death certificate be exigned by the attending physician d be detached for use as the burial by Physician/Medical E.	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat	eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
rds, Purios that haif be deta	art II. Other significant conditions contributing to death but not resultin $\wp_{\mathcal{M}}$	ng in the underlying cause given in Part I. 23e	Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
law law	A13 relineus CAO	10	. Was an autopsy performed? Yes 2 SNo 24b. Were autopsy findings available prior to completion of cause of death? 1 SY Yes 2 No
Phys of C	7. Manney of Death 1 Statural 5 Pending (Month, Day Year) 28 Accident investigation	Bb. Time of 28c. Injury at Work? M 1 Yes 2 No	Residence 6 Other (Specify)
DIVI. DIVI. Ppital or At a safer of a safer of safer or	4 Homicide determined building, etc. (Specify)	e, farm, street, factory, office 281. Loca City adde, death occurred at the time, date and place, and due	ation (Street and Number or Rural Route Number, or Town, State)
Division To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the funer Medical Certification	one) and manner stated.	n and/or investigation, in my opinion, death occurred at the	29d. Date signed (Month, Day, Year)
C, H. 3	D. Name and address of person who completed cause of death (Item 23)	29c. License number H50457 Ba) (Type, Print) O// St. Sa/Isbury mb	3 /29/0]
	1. Date filed (Month, Day, Year) MAR 3 1 2005	Sports	

			1 - State Unpend Item 2	State of Ma 3a&27 per	ryland/D me G842	epartme Certifica	nt of H	ealth ai Seath	nd Meni	tal Hygi	ene	05	12569	
	01		1. Decedent's Name (First, Middle, Last) 2. Date of Death							Veer	3. Time of Death			
	Physici /Medi		John Donovan						Aï	oril 2	, ^{Day} 200	5 Year	2330Р. м	
	Examir		4a. Fecility Name (If not institution, give street and number) 2125 Parkers Creek Rd.				4b. City, Town, or Location of Death Port Republic					4c. County of Death		
			5. Social Security Number 6. Sec		(In yrs. last birt	-	er 1 Year		William Co. Of The Co.					
	Funeral Director			M 2□F		frs. Months		Hours		ate of Birth Month, Day, ULY,	1957	Coun	lace (State or Foreign itry) nington DC	
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "retural", or items 23s or 28e-f show entry injury or other treumatic event, the Medical Exemples must be nuitiled at ances.	ctor	10a. State 10b. County		10c. City, Town	or Location						1	Od. Inside City Limits	
			Maryland Calvert Prince Frederic					ck					1 ☐ Yes 2 ☐ No	
		Dire	10e. Street and Number									of What Cour	,	
215-0036		ral	P.O. Box 2466									d Stat		
		Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?		13. Was Dec If Yes, sp	Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric			lican, etc.)		14. Race - American Indian, Black, White, etc.		
		þ	3 Widowed 4 Divorced	If Yes Give			1 ☐ Yes 2 ☐ Mo Specify:					Specify: White		
		eted	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind				ent's Usual Occupation 16					b. Kind of Business/Industry		
21	ithin ne.	Completed	Elementary/Secondary (U-12) College (1-4or 5+)				kind of work done during most of working DO NOT use retired)							
121	iled w Hygiei ther ti		1 Z 17. Father's Name (First, Middle, Last)	Plum		umber						elf Employed		
Maryland	d be f antal } ted of	o Be	Jeremiah Fran	cis Dono	ovan				_	(First, Middle, Maiden Sumame) Jane Goffe				
Z	shoule nd Me mark imatic	10	19a. Informant's Name/Relationship (Ty			Mailing Addre	ss (Street a				ber, City or Town, State, Zip Code)			
	and 2 salth a n 27 is		Jeremiah John Don	ovan (Brot	her) 61	.01 Blu	e Wha	le Cou	irt, Wa	aldorf	, Mar	yland	20603	
Baltimore,	of Health of Health litem 27 i		20a. Method of Disposition		20b. Place of cemeter	Disposition (N.	ame of other place	9)	Date	2	Dc. Location	n - City or To	wn, State	
Ē	Pages ment of I ent: If its ury or o		t ☐ Burial ※X☐ Cremation 3 ☐ R * 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Lee Cr	rematór	y Apr	il 5,	2005		Clint	on, Ma	ryland	
3alt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service License	11							,		33 01d	
_			Alexandira Ferry Road, Clinton, Maryland 20735											
	ী Physician		23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive atherosclerotic cardiovascular disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
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	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last		consequence o	f):				_		_		
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Вох	ne death certificate be executed the attending physician and hed for use as the burial-transit	M/u	IF FEMALE: 23c. If yes, outcome of pregnancy 1							23d. D	23d. Date of delivery Month Day Year			
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Vital Records,		Completed												
Rec	The law	mpi							2	24a. Was an autopsy findings availal prior to completion of cause of death?			psy findings available apletion of cause of	
G		မ လ	25. Was case referred to medical							1 Yes 2 No 1 Yes 2 No				
S		0 13	examiner?	lospital:	t 2□ER/Out	nationt 3 🗆 🗆	26. Place of Death Check on one DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) (SCENE)						(scene)	
l of		P- 1	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. [d. Describe how injury occurred					
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ivi	I or Attencatter death	rtific	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ce of Injury - At home, farm, street, factory, office 28f. Locatio city or 28f. Locatio					ocation (Stre	on (Street and Number or Rural Route Number, r Town, State)			
Ω	lospitel or hours atte unerel Dir	edicai Cer												
	Hos Hos Fur		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Exeminer: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
and manner stated. 29c. License number 29d. Date signed 29d. Date signed 29d. Date signed								(Month, Day, Year)						
	*	Josho Deenley MD OCME April 3, 200							o, 200)				
				mpleted cause of dea	ath (kam 23a) (Type, Print)	11 Pa	nn Sti	reet	Raltim	nore	Marvile	and 21201	
	M 20 - 21		31. Date filed (Month, Day, Year)	100 n hze r 32. Registrar	's Signature), -						1 K41 Y 10	212UI	
87	Sta Registr	- 1	APR 1 2 2005	all was	A A	will								

				Mental Hygiene								
	Physic /Medi		1. Decedent's Name (First, Middle, Las Mary	•		rsett	sett		, 2005	Year	3 Time of Death 0 11:04 PM	
}	Examin Funeral Director		4a. Facility Name (If not institution, give Beverly Health (5. Social Security Number 212-38-9645	Care Center		4b. City, Town, or Hager Hager Months Days Hours Min		stown	Vear 1938 Ma:		n	
	e Maryland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location						10d. Inside City Limits			
			West Virginia Jefferson Kearneysville ¹\(\time{\chi}\)Yes 2□								1∏ Yes 2□ No	
	th with the 23a or 2	al Dire	10e. Street and Number 1871 Wide Horizon Blvd 25430					10	g. Citizen of V U.S		try?	
020	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show the Madical Examiner must be notified at	To Be Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto If Yes, Give A Year or Dates:					pecify Yes or No- Rican, etc.)		ce - America ck, White, e		
Maryland 21215-0020			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name					king	16b. Kind of Business/Industry Public School			
d 2	filed Hygi ther							ne (First, Middle, M	OI			
ylan			Harry Eugene We	enner			Alice	Louise V	Wiles			
	nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship (7) Mary Prichard/Daug				eet a <i>nd Numb</i> er or Ru orizon Blv				<i>сыды</i>) W. Va. 254	
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2: any injury or other once.		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	Removal from State	Ob. Place of D cemetery, 1t. Oli	isposition (Name of crematory or other p Vet Cemet	olace) ery Apri	Date 2	oc. Location - 5 Fred	•	wn, State k, MD	
Balt			21. Signature of Funeral Service Licensee M00021 Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701									
7	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Dry game with the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death If the mode of dying, such as cardiac or respiratory arrest, Duetto (or as a consequence of):									
	certificete be executed rding physician end use es the buriel-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter funderlying Cause (Disease or injury that initiated events resulting in death) Last b. Dimetroic. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Box	death ne atte ed for	Physician/N	Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tob	acco use cor	ntribute to	the cause of death?	
s, P.O.	es that the death cert igned by the attendin be detached for use	by Phy						1 □ Yes	a 2□ No	3 🗆 Prob	ably 4 🔀 Unknown	
Division of Vital Records,	requir been s should	Medical Certification: To Be Completed b				- 80 - 100		24a. Was an performe	autopsy ed?	avai	re autopsy findings ilable prior to appletion of cause eath?	
<u>ھ</u> ھ	: The l cate h;							1 ☐ Yes	2 / Q No	10	Yes g □ No	
<u> </u>	sicien c certifi lirectol		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 □ EB/Outpo	tient 3 DOA		h (Check only one)		ne (Canaihi	1	
2	ling Afte fune		27. Manner of Death 15 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?				me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
Divis	To the Hospital or Attenc within 24 hours efter death To the Funeral Director: completely filled in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp	Place of Injury - At home, farm, street, factory, office 28 utilding, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	re nospit		29a. Certifier (Check only one) 154 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the comp		29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number					29d. Date signed (Month, Day, Year)				
2	B)		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Ty	pe, Print)	11-0300		4-5	-05		
	ار	Å	MAN 2-AL. JSF 31. Date filed (Month, Day, Year)	1 AM. 362 32.Registrar's S	8 nill ignature	strul	1+ages to	nu 17.	D	1740		
45	Registr		APR 1 2 200	5 Person	11. 1	Carto)						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Maria Antonia Estrada 10:55 P^M 03 26 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wheaton Manor Care Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F 578-52-5654 Director 03/01/1914 91 Guatemala Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or items 23s or 28e-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4414 Hallet Street 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or item any injury or other treumatic. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ♥ Yes 2 □ No Specify: Guatemalan þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 House Keeper House Cleaning 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Unknown Unknown Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabel Estrada - Niece 2601 Camelback Ln #6 Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State b * 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven 03/30/2005 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave Silver Spring, MD 20904 ala 0 (23a. Part1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 Weeks Brain Tumor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 XNo
9 ☐ Unknown Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Seizures hes autopsy perform this certificate 2 X No 1 Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Atter 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire TC Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO057636 tuz 03/29/2005 , M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun, MD 10301 Georgia Ave Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

MAR

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ∫ Year 3. Time of Death Day **Physician** TERESA LYNN ELBEN MARCH 2005 28 11:50AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 31585 TAPPERS CORNER ROAD CORDOVA TALBOT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. JULY 12 1961 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1□ M 2X F Months MARYLAND Yrs. 43 Director 219-86-4955 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or items 23e or 28a-f show treumatic event, the Medical Exama as must be redified at 1 ☐ Yes 2X No TALBOT CORDOVA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23e any injury or other treumatic event, tre Wedgel Expressiones. 31585 TAPPERS CORNER ROAD 21625 AZU Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ VETERINARIAN 12 MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PAUL E. HIGGINS MARY GERTRUDE CRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL WAYNE ELBEN/HUSBAND 31585 TAPPERS CORNER ROAD, CORDOVA, MD 21625 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) ANATOMY GIFTS REGISTRY 3-29-2005 HANOVER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST. EASTON, MD 21601 MERCERON JOHNR. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** omo. /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 900A Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**2**No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗆 No 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Certification: To this 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify D35281 3/29/05 ted cause of death (Item 23a) (Type, Print) and address of person S. Washington St Easton mo 10 219 no 32, Registrar's signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24ª Mary K. Elliott 2005 Mar. 5:20a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Dec. 15, 1914 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🔀 F 90 Director Yrs. 219-10-5008 with the Maryland 10a. State 10c. City, Town or Location 10b. County 17 Is marked other then "netural", or Items 23e or 28a-f show treumatic event, the Medical Examination and Les routified at 10d. Inside City Limits MD Anne Arundel Completed by Funeral Director Severna Park 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Kimberly Court 21146 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Inportent: It item 27 le marked other then "netural", or Items 23e any injury or other treumatic event, the Medical Examples. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, et 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Kopper Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Engelman Mary Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank R. Elliott, Jr. 1629 Grandview Road, Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mar. 26, 1 Burial 2 Cremation 3 Removal from State Metro Crematory Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Moma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dire to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit ding physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 3 ☐ Probably 4 Monknown 1 ☐ Yes 2 ☐ No Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? 1 Yes 2 Do funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) . To Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No after death. 2 Accident the f Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 0 3 2 6 6 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who coll pleted cause of death (Item 23a) (Type, Print) Darko Drue 210 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Amended Item 25 per Physician & Item 31 per Carroll Co. H.D. 03/30/2005 wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mantal Hygians or any

			1 - For State Registrar	State of Ma	ryland		rtment of H		d Mental H	ygien Reg. No	- 000	12574
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) 4a, Facility Name (If not/institution, give	rue t	CK	KeR	4b. City, Town, o	or Location of C	2. Date of E Month	2 Da	Yea	5 1034M
	Examir Funeral Director	ier	5. Social Security Number 6. Sep	tal (8	1) H (In yrs. Ia 79	est birthday).	If Under 1 Year Months Days	If Under 24	ste R	- (ark	hirthplace (State or Foreign Country)
	D.		Usual Residence of Decedent 10a. State 10b. County	Α		Town or Loc	eation		(ME (CL)		1923 F	10d. Inside City Limits
	with the Ma s or 28a-f s be notified	Director	MARYLAND CARROLI 10e. Street and Number 104½ PENNSYLVANIA		WES	TMINST	ER 10f. Zip Code 21157				tizen of What (•
36	be filed within 72 hours after death with the Maryland tal Hygiene. dother than *natural; or items 23a or 28a-f show event, the Medical Examinational be routified at	by Funeral		12. Was Decedent E Armed Forces? 1 ☐ Yes Yes, Give Year or Dates:		ł			? (Specify Yes or Nuerto Rican, etc.)		14. Race - An Black, Wh	nerican Indian,
Maryland 21215-0036	a filed within 72 hou il Hygiene. other than "natura vent, Iha Medical E	Completed	15. Decedent's Edu (Specify only highest grade	cation	+)	(Give k	ent's Usual Occup tind of work done O NOT use retired	during most of d)	working	16b. K	and of Busines	
yland;	should be filed ind Mental Hygie marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) CHARLES EZRA FISHER	3					Name <i>(First, Middl</i> CHE VIOLA			
	and 2 ealth a m 27 is	1	19a. Informant's Name/Relationship (Ty, M. EDNA STAUB/SISTE		OOL DI-	0146	TANEYTOW	and Number o		NSTE	R, MD	21158
Baltimore,	Page nent o ant: # ury or		20a. Method of Disposition AB Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)		cen	EVIEW	ition (Name of atory or other place MEM PARK	3,	Date /30/2005		Cation - City of KESVILL	or Town, State E, MARYLAND
Ba	permit. Departr Importa any inji		21. Signature of Funeral Service License	aherty.	Kyl	K 31	WILLIS	RAW FUI STREET	VERAL HOM WESTMI	NSTEI	A. R, MD	21157
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Undertying Cause (Disease or injury	Due to (or a	conseque	nce of):	•	· a	ndvo-	~~		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or infury that initiated events resulting in death) Last	Due to (or as a	conseque	: 11a- ence of): s cl-	7		dision	3	lass urtu	months
P.O. Box 6	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ √√0 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal d	leath 3 □E	Ectopic pregnancy Other (specify)				23d. Date of do Month	elivery Day Year
rds, P	w requires that been signed b should be dett		Part II. Other significant conditions con	tributing to death but	not resulti	ing in the und	derlying cause give	en in Part I.		tobacco u	_	to the cause of death? Probably 4 All-Iknown
Vital Records,	Attending Physician: The law is at death. ector: After this certificate has be by the funeral director, page 2 shu	Completed							1 ☐ Yes	psy ormed? 2 12 No	prior to death?	utopsy findings available completion of cause of s
	hysicia this certi	To Be	IM tes Egino	ospital: 1 4 inpatient	_	R/Outpatient		er: 4 🗆 Nursin	Death <i>(Check only</i> g Home 5 ☐ Res		6 □Other (Spe	ecify)
Division of	Attending Physician: r death. sctor: After this certific. by the funeral director,	atlon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	28c. Injury Work	vat ⟨? Yes 2 ☑ 146	28d. Describe	how injur	y occurred	
DIX	하루등도	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	(Specify)				City or To	wn, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of ier: On the basis of e and manner state	examinatio	edge, death on and/or inve	occurred at the time estigation, in my op	e, date and planting death of the second sec	ace, and due to the ccurred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
		Σ	29b. Signature and title of certifier	0	N 19	}	29c. License		-,-,		e signed (Mon	• • • •
	NJL 3		30. Name and address of person who con	mpleted cause of dea	ath (Item 2	(3a) (Type, P	rint)	5	su - L	101	<u>> ادا ک</u>	-26-05
	Sta Registra		31. Date filed (Month, Day, Year)) 2005	le .	M	Land.		・ノベー・・	40,000

Physici		Registrar 1. Decedent's Name (First, Middle,	State of Ma 23a&27 per		Oerinicale C) Dean	2. Da	e of Death		UD	3. Time of Deat
/Medi		Robe	rt Anthony	Earl				ril 6,	Day 2005	Year	9:00 A
Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Tow	n, or Location	of Death		4c. County of	of Death	
		Union Hospital 5. Social Security Number 6	S. Sex 7. Age	e (In yrs. last bii	E1kton		r 24 Hrs. 8 Dat	e of Birth	Cecil.	O Distri	I (C+-+ #-
Funeral Director		216-82-5352 Usual Residence of Decedent	1 X M 2 □ F 3:		Yrs. Months Da		Min. (Mo	ch 15,	1972	9. Birthp Coun Mar	lace (State or Fore try) Tyland
how		10a. State 10b. County		10c. City, Tow	n or Location					10	0d. Inside City Lim
89-fs pulling	Directo	Maryland Cecil		E1kt							1 X Yes 2 □
a or 2 Lban	급	10e. Street and Number 117 Rudy Park			10f. Zip Cod 219				Citizen of W United		
ms 23	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. Was Decedent if Yes, specify (rigin? (Specify Ye		14. Race	- Americ	an Indian,
or Ite		1 XNever Married 2 ☐ Married	Armed Forces? d 1 ☐ Yes 2 🛣 N If Yes, Give	lo	If Yes, specify €			etc.)		c, White, e	
urel',	d by	3 Widowed 4 Divorced	Year or Dates:				•	<u>,, </u>	Specify:	вта	
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Menta arked atic e	70 E	Tony Martin				No	la Doree	n Earl			
Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neturel", or Items 23a or 28e-f show my injury or other treumatic event, the Medical Examinat must be notified at once.		No1a D. Ear1/M	. ,, . ,		o. Mailing Address <i>(Str</i> 8 Carper S						Code)
of He fitem rothe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□ Removal from State	20b. Place o cemete	of Disposition (Name of	f place)	April 10	20c.	Location - C hesape	City or To	wn, State City
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Department Importent: If eny injury or once.		21. Signifure of Funeral Service Lie	censee		Hicks Ho	ddress of Facil me for	Funera1	s. P.A			
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		Immediate Cause (Final disease or condition resulting in death)		sive ca	rdiovascul			atory arrest,			
ledical aminer	Examiner	disease or condition	a. Hyperten Due to (or as b. Due to (or as c.		rdiovascul			atory arrest,	•	•	Interval Between
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	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic Examir		RICHARD FETTERS 4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Deat	03		005 aty of Death	2:00 A M
	Exami	er	Holy Cross Hospita	_		Silver				gomery	y
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			-	lace (State or Foreign
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	arylan show	_	10a. State 10b. County	10c. City,	Town or Lo	cation				1	Od. Inside City Limits
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	with t	Funeral Director	10e. Street and Number	•		10f. Zip Code 20852			10g. Citizen o	of What Coun ed Stat	
	death ms 23	era	6305 Tuckerman Lan	2. Was Decedent Ever in U.S	. 13. V			Specify Yes or No-		ace - Americ	
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-1 show any loury or other traumatic event, the Medical Eventher must be notified at once.	۾	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	r "	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 XNo	n, Mexican, Puer Specify:	to Rican, etc.)		lack, White, cify: White	etc.
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Maryland	ntal H ed otl	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Sum	ame)	
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ē,	s 1 a/f Hea		20a. Method of Disposition	20b. Pla		sition (Name of natory or other place		Date	20c. Location		wn, State
Ë	Page nat: #		1√2 Burial 2 ☐ Cremation 3 ☐ Rer 1√2 Burial 2 ☐ Cremation 3 ☐ Rer	noval nom state		d Mem Gno	1 .	30/2005	Falls	Churc	h, VA
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S, D	uires that n signed b	by	Part II. Other significant conditions contr Hypertension	ibuting to death but not result	ing in the un	derlying cause give	n in Part I.				e cause of death?
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ita		BeC	25. Was case referred to medical	riciency			26. Place of Dea	ath Check on or		1 🗆 1 03	2 140
of V	physician: this certific al director,	10 E	examiner? 1 ☐ Yes 2 🛣 No Ho:	spital: 1 ☐ Inpatient 2 🏋 El	R/Outpatient	3□ DOA Othe	r: 4 🗆 Nursing H	lome 5 ☐ Resid	ence 6 🗆 O	ther (Specify)
o uoi	ding f	ertification;	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work M 1 \(\) \(\)	at ? ′es 2 □ No	28d. Describe h	ow injury occu	urred	
Division	al or Attano atter deatl Director: d in by the	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Town		nber or Rural	Route Number,
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Cartifying Physic (Check only one)	cian: To the best of my knowl r: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	e, and due to the curred at the time, d	ause(s) and n late and place	nanner as sta e, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2 2440		29c. License	number	2	29d. Date sign	ed (Month, L	Day, Year)
)	12		Kabert H. X	ecae (MI)		D005	5522		03/28/	2005	
	(*		30. Name and address of person who com	pleted cause of death (Item 2	3a) (Type, F						
			Robert H Gerard, MD	1500 Forest (Glen R	oad Silve	er Sprin	g,MD 209	10		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 200	32. Segistrar's Signatu	A A	gass)					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician ELLA** FIFE MAE 28, 12:10PM 2005 March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M SENE 88 415-32-8426 Yrs. Director Georgia Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits Md. Montgomery Wheaton 1XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1916 Ventura Avenue 20902 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: by Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Williams Ella Crockren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty McClamy/Daughter 1916 Ventura Ave., Wheaton, Md. 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/4/05 Brentwood, Md. Fort Lincoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature of Funeral Service Licensee Mackey l.to 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer /Medical Due to (or as a consequence of) Examiner Multiple Electrolyte Abnormality Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law raquires that the death cartificate be exacuted the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably YNUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2X No 1 Yes I or Attending Physicien: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) D5098 A. Naunas 3-29-05. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po GAITHERSBURG MD 20883 BOX 83819 mo NAWAZ 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State MANUEL Registrar

		1- State of Maryland / Departn Registrar/AMEND#7perFH3/30/05, BWW, McCo Certific	nent of Health and M cate of Death		iene og. No. 005 2571
Physici /Medic		1. Decedent's Name (First, Middle, Last) FROME Forem		2. Date of Death Month	Day Year 252 A
Examir		Hoy Cross Hospital S:	City, Town, or Location of Death Liver Spring		4c. County of Death Montgomery
Funeral Director		578-42-0954 1 M 2 F -92 91 Yrs. Moi		8. Date of Birth (Month, Day, June 5	
the Marylan 28a-f show	Director	Maryland Montgomery 10c. City, Town or Location Silver Spri		16	10d. Inside City Lim Yes 2 Og. Citizen of What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exertities to intiffed a spice.	by Funeral Di	711 Horton Drive 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	20902 Decedent of Hispanic Origin? (Spespecify Cuban, Mexican, Puerto l		14. Race - American Indian, Black, White, etc. Specify: WHITE
within 72 housne.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Usual Occupation of work done during most of workil OT use retired)	ng 1	6b. Kind of Business/Industry
uld be filed v Mental Hygie irked other t	To Be Co	!2 4 Teac 17. Father's Name (First, Middle, Last) Joseph Michael Roberts	18. Mother's Name	(First, Middle, M	
and 2 sho salth and I n 27 Is me		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add Jane Myra Forer_Gentleman (daugher)	lress (Street and Number or Rura	l Route Number,	
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Depa Impo any i			lox 5800Washingt	on DC 20	ortuary Services 0037 st. Approximate
death certificate be executed Wedical Examiner of for use as the burial-transit	ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Interval Between Onset and Death
death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ector 4 ☐ Pregnant at time of death 5 ☐ Othe	ic pregnancy r (specify)		23d. Date of delivery Month Day Year
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occu 2 Medicel Examiner: On the basis of examination and/or investigated and manner stated.	red at the time, date and place, a tion, in my opinion, death occurre 29c. License number	d at the time, date	use(s) and manner as stated, e and place, and due to the cause(s) d. Date signed (Month, Day, Year)
		30. Name and agoress of person who completed cause of death (Item 23a) (Type, Print)	20059633 Lano Marie	al Cons	13/26/2005
Sta Registra		3 Date filed (Month, Day, Year) MAR 3 0 2005 3 Registrar's Signature	12# Mercan	file L	aue 2077

			For	State of Ma	aryland / Dep				and M	lental Hy	giene	nne	10576
			State Registrar		Ce	rtificat	e of l	Death			Reg. No	F 00.	1 12015
	Physicia		Decedent's Name (First, Middle, Las							2. Date of De Month	Da		3. Time of Death
	/Medic	al	Paul Winsto		r	Ah Cib.	Tour	Location of		MARCH	2	9 200 : County of D	
	Examin	er	4a. Facility Name (If not institution, give	. /	Porter	4b. City,	TOWN, OF	alish	/M		40		OMICO
	Funeral		5. Social Security Number 6. So		e (In yrs. last birthday, 79 Yrs.	If Under Months		If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year,	9. 1	Birthplace (State or Foreign Country) est Virginia
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	be filed within 72 hours efter death with the Maryland hall Hygiene. And other then "natural", or itams 23e or 28e-f show event, the Modical Examinational to notified at	5	10a. State 10b. County		10c. City, Town or L								10d. Inside City Limits 1 ☐ Yes 2 🔀 No
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	ms 23	Funerai	11. Marital Status	12. Was Decedent		Was Dece	dent of H	ispanic Ori	gin? (Sp	ecify Yes or No			merican Indian,
	or ital		1 Never Married 2 Married	Armed Forces?	^{No} 1943 to	1 ☐ Yes		n, mexican Specify:	i, Puerto	Rican, etc.)		Black, W	
	raf, c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1945	1 🗆 1 63	2L X (40	эрөспу.				Specify:	
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•	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address	s (Street	and Numbe	or Rur	al Route Numb	er, City	or Town, Stat	e, Zip Code)
	s 1 and 2 of Health a item 27 is other tra		Patricia M. Fori	nger (wife	522	Oce	an P	arkw	ay,	Ocean			
			20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Disp cemetery, cre	matory or o	other plac			Date			or Town, State
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	permit. Page Department of Importent: If eny injury or once.		21. Senature of Funeral S. Arica Licen	1500							_		al Home
	40 = 9 Q		23a Part1. Enter the disease, or com	plications that cause						erlin, M		21811	Approximate
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	that i		Part II. Other significant conditions of	contributing to death t	out not resulting in the	underlying	cause giv	en in Part I		23e. Did	obacco	use contribut	e to the cause of death?
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune				of my knowledge, dea of examination and/or i								
	the f	Medical	one) 29b. Signature and title of certifier	and manner s				e number					Ionth, Day, Year)
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7	1 ()		Charles Dis		rar's Signature								

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MARCH 29, 2005 \mathbf{A}^{M} DOROTHY MARION GUYTON 8:54 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 97 MD 214-01-3218 DEC. 31, Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or Itams 23a or 28a-f show 1 ☐ Yes 2 X No Director QUEEN ANNE'S MD **STEVENSVILLE** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 260 GUYTON LANE 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE by 3 XWidowed 4 ☐ Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) 9 TELEPHONE OPERATOR COMMUNICATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fill h and Mental H 7 is markad ott Be MARION PARSONS ELIZABETH (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is rr any injury or other traum once. NANCY M. GUYTON/DAUGHTER-IN-LAW 251 GUYTON LANE, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 04/01/2005 STEVENSVILLE, MD 21. Signature of Fuperal Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Myocandia nt disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy page certificate 1□ Yes 2-No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 Hipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attanding 1. Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funaral Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1005 7635 29. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical 2001 woons 2005 Registre's Signature 31. Date filed (Month, Day 1997)

DHMH 17 Rev 1/200

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			For Stata Registrar	State of N	Maryland		artment rtificate					ene)5	12581
	Physici	an	1. Decedent's Name (First, Midd								2. Date of Death Month	Day	Year	3. Time of Death
	/Medi		ELVA SNOW GERM 4a. Fecility Name (If not institution		or)		4b. City.	Fown or	Location of		MARCH	28 2 4c. County	005	12:02 A ^M
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	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. las	t birthday)			If Under:	24 Hrs. 8 Min.	Date of Birth (Month, Day,			lace (State or Foreign
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	h the or 28a	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of \	What Coun	itry?
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>	v v		30. Name and address of person	who completed cause of	death (Item 23	a) (Type, 1	Print)	1,0	Sie	771 1	mnan	le v	NO	711111
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			For State Registrar	State of Ma	-				and M		-20	05	12582
			1. Decedent's Name (First, Middle, Last)									Voor	3. Time of Death
			PAUL EDWARD GARR	ETT						MARCH	30	2005	5:20AM M
			4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location of	of Death		4c. Count	y of Death	
	Physician PAUL EDWARD GARRETT 2.0 but of hearth worth whether 30 2005 2005				TALBO								
			118							8. Date of Birth (Month, Day,	Year)	Coun	lace (State or Foreign
	Director		218-03-/24/		89 118.					OCT 22	1915	MARY	LAND
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Baltimore,	rmit. partin porte y inju		21. Signature of Funeral Service License	90		22. Name an	d Addres	s of Facilit	у			4450 4440	
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н			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each li	I the death. Do not e ne.	nter the mod	e of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
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			resulting in death)	Due to (or as	consequence of):	1	101	1		11	1.		
	LAGIIIIII	_	Sequentially list conditions b	Due to (or as	a consequence of):	برب	Ch	refl	00	V STOUCH	1/6		y-lays
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Вох	th cer endir r use	an/N	23b. Was decedent pregnant			□Ectopic pr	egnancy						
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P.0	d by t detact	Phy		stributing to dooth h	ut not reculting in the	undorhina a	auca awa	on in Part I		23e Did toh	acco use con	atribute to th	ne cause of death?
ŝ	ires ti signe	þ	77 Ave U		n . '	andonying o	uusu giri	5// // / W/(//	•			3 ☐ Prob	
9	requ	etec	- / April 11	200-	1-211-00					MORELL SEAR		Special Co	
Records,	has l	ig E			/					autopsy	/ _ /	prior to cor	npletion of cause of
<u>a</u>	n: Th ificate or, pa		25. Was case referred to medical					GE Bloom	of Doath			1 🗆 Yes	2□ No
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o		 	27. Manner of Death				100	11/19/14					,
io	Attending r death. sctor: After by the fune	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Du	y roury mijury	м		Yes 2 □ I	No				
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, factory	, office		2	28f. Location (Str City or Town		ber or Rura	l Route Number,
۵	oitel or urs afte rel Dir lled in												
	To the Hospitel c within 24 hours af To the Funerel D completely filled in	Medical	29a. Certifier 1 Certifying Physics (Check only 2 Medical Examination)										
	To the within 2 To the comple	Me	29b. Signature and title of coeffer	8 IM	7)	290	. License	e number	->	29	d. Date sign	ed (Month,	Day, Year)
			* KULDIN	I PY			2	5/5	0	5	130	105	
	1)		30. Name and address of person who co	ompleted cause of d	leath (item 23a) (Typ	e, Print)					1		
1	(g)		ROBERT B. SANCHEZ		8 IDLEWIL	D_AVE_	EAST	ON, M	D 21	601			
	Sta Regist		31. Date filed (Month, Day, Year)	2. Hegistr	ar's Signature								

			1 - For State Registrar	State of Maryla		artment of rtificate of			Reg. No.	005 1258	3 3
	Physici	an	Decedent's Name (First, Middle, Last)	Remberto	Gome:	7.		2. Date of Do	Day	Year 3. Time of Death	М
A Section	/Medio Examir		4a. Facility Name (If not institution, give s Hebrew Home			4b. City, Town,	or Location of C		4c. County	y of Death Ontgomery	
7	Funeral Director		5. Social Security Number 6. Sex 578–76–6243	7. Age (In yrs	(last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D) Feb 4,	rth ay, Ye <i>ar)</i>	9. Birthplace (State or Foreig Country) SEI Salvador	gn
	with the Maryland a or 28a-f show	Funeral Director	10a. State 10b. County Maryland Montgom 10e. Street and Number 4414 Randolph Ro	nery	ity, Town or La	Silver S	oring 20906		10g. Citizen of	•	
-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28a-f show stry hjury or other traumatic avent, the Modical Exer'il art traint Lie notified at ance.	ρ	_	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cult 1	Hispanic Origin pan, Mexican, F Specify: F	1? (Specify Yes or No Puerto Rican, etc.)	rian Specif	JSA ce - American Indian, ick, White, etc. fy: White Business/Industry	
Maryland 21215-0036	filed within 72 Hygiene. other then "ne ent, I're Madic	Completed	(Specify only highest grade Elementary/Secondary (0-12) 6th 17. Father's Name (First, Middle, Last)		(Give life. I	kind of work done DO NOT use retire Maintenar	during most of ed) nce Wor		Pri	vate	
arylano	should be tind Mental I is marked or umatic ave	To Be	Raymondo Rosal 19a. Informant's Name/Relationship (Typ	oe, Print)			t and Number o	Lucia Go	OMEZ ner, City or Town,	, State, Zip Code)	
	1 and 2 Health a lem 27 is		Maria Gomez (Wife		Place of Dispo	sition (Name of		, Silver S		MD 20906 - City or Town, State	
Baltimore,	Pages ment of lant: If It jury or o		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	G	ate of		3/:	31/2005	Silver	Spring, MD	
Ball	permit. Page Department of Important: If any injury or once.		21. Signature Funeral Pervice License	Dul -	22			Rendon/Hal Road, Lar			
	Physician /Medical Examiner	Examiner	23a. Parti. Enter the disease, or complic shock, or heart failura. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):			rdiac or respiratory a		Approximate Interval Between Onset and Death	
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a conse	ancy	Ectopic pregnand Other (specify)	э			ate of delivery	
s, P.O.	res that the de igned by the be detached	by Physi	1 Yes 2 No 9 Unknown Part II. Other significant conditions con	9□ Unknown tributing to death but not re	sulting in the ur	nderlying cause gi	ven in Part I.	23e. Did	obacco use cont	tribute to the cause of death?	
Division of Vital Records,		Completed					-	24a. Was	an 24b.	3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	9
<u> </u>	ysician: Th is certificate director, paç	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospita(: 1 ☐ Inpatient 2 ☐] ER/Outpatien	t 3 DOA Ot	The state of the s	Death (Check only on the property of the prope		er (Specify)	
sion o	Attending Physician: r death. sctor: Afler this certifica by the funeral director, p		27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ryat ork?]Yes 2 ☐No	28d. Describe	how injury occur		
Divis	or Dire	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec.	ify)			City or To	wn, State)	oer or Rural Route Number,	
	To the Hospitel within 24 hours a To the Funeral I chmpletely filled	Medical	(Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	vestigation, in my	opinion, death o	place, and due to the occurred at the time,	cause(s) and ma date and place,	inner as stated. and due to the cause(s)	
)	To the crmple	Σ	29b. Signature and title of certifier 7 msuch	Mineza		29c. Licen		>	_	d (Month, Day, Year)	
2	(4)		30. Name and address of person who con			Print)	NSUELO	Mu	thee,	mg 26, 2005 -	
100	Sta Registr		31. Date filed (Month, -Day, Year) MAR 2 9 2005	2. Registrar's Sign	ature	Ri	n.,	NO		š.	

DHMH 17 Rev 1/2001

Remberto

Gomez,

		1	For State Registrar	State of Marylan		artment of He tificate of L			giene Reg. No. "	05	12584
	District.		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic	al	Benjamin Lee Gary						28 200		4:15 a ^M
	Examin	_	4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Deat	h	4c. County		rga
			Southern Maryland F	lospital 7. Age (In yrs.	last hirthday)	Clinton If Under 1 Year	If Under 24 Hrs	8. Date of Birtl	h	9. Birtho	ace (State or Foreign
	Funeral Director			47 2□F	Yrs.	Months Days	Hours Min.		, Year)	Coun	ington, DC
		-	Usual Residence of Decedent					500. 15	, 1,,,,		
	yland how		10a. State 10b. County	10c. Cit	ty, Town or La	cation				1	0d. Inside City Limits 1 Yes 2 No
	a-f a	cto	Maryland Prince Geo	orge C1:	inton			Т-	10g. Citizen of V	W	
	ith th	Dire	10e. Street and Number	ano		10f. Zip Code 20735			United		
	e 23e	rai	6501 Spring Brook	2. Was Decedent Ever in U	S 13 1	Was Decadent of Hi	spanic Origin? (5	Specify Yes or No-		e - Americ	
36	s 1 and 2 should be filed within 72 hours effer death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or iteme 23e or 28e-f show other traumatic event, the Medical Examinating to notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 ②No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	to Rican, etc.)	Blac	k, White, /: Bla	
21215-0036	tural	edi	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	ation	orking	16b. Kind of Bu	usiness/Ind	dustry
215	within 72 ene. than "na the Medi	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	DO NOT use retired)	irkirig			
212	giene grene er the	Completed	12		Cool	ζ			Priva		
	and 2 should be filed within salth and Mental Hygiene. n 27 is marked other than "ser traumatic event, the Mer	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na Junnie	me (First, Middle,	Maiden Suman	18)	
yla	Ment Ment arkad	ပ္	Oscar Gary		401 14 111	ng Address (Street a			City of Tour	State Zin	Code
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (Type Patricia A. Brown/			Bullock				740	0006)
e,	1 and 2 Health sem 27		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date	20c. Location -		own, State
סר	ages nt of h	13	1 Burial 2 □ Cremation 3 □ Re	moval from State	-	matory or other plac Memorial	1	./05	Landove	r. MT)
Baltimore,	ortme ortant ortant injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License			2. Name and Address Lexander				_ ,	
Ba	permit. Pages 1 and Dependment of Heali Important: If Item 2 any injury or other 2008.		1 Mutte Ku	1000	A.	lexander 538 Marlb	S. Pope oro Pike	Funeral Forest	Homes	MD 2	20747
			23a. Part1. Enter the disease, or complice shock or heart failure. List only one	ations that caused the dea	th. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a consec	dence of):	1	,				
	Examiner		Sequentially list conditions, b.		45						
	sit 9d	ine	Sequentially list conditions, in any, leading to inmissional cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quartea ory:						
_	certificate be executed ding physician and ise as the burial-transli	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):						
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687	flicate g phy: as the	edic								ŀ	
O. Box	death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ZZZNo 9 ☐ Unknown	Sc. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3[⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>	/		4	te of delive onth	ery Day Year
ص	requires that the een signed by th nould be detache	y Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the t	underlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
rds	quires n sigr uld be	d by						10	Yes 2□No	3 🗌 Prot	oably 4 Dunknown
Vital Records,	> 0 %	Completed						24a. Was		Were auto	ppsy findings available impletion of cause of
Re	0 5 0	E						perfo	ormed? 2XNo	death? 1 🗌 Yes	
ital	ician: The certificete rector, pag	a	25. Was case referred to medical					eath (Check only o	one)		
	d is	To B	examiner?		☐ ER/Outpatie		4 Indiania	Home 5 Resi			fy)
0 U	Jing Ph J. After th funeral		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	rk?	28d. Describe	how injury occur	rred	
Sio	Attending r death. ector: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be			_	Yes 2 □No	28f Location /	Street and Num	her or Rur	al Route Number,
Division of	i giệc	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, rarm, s cify)	treet, ractory, onice			wn, State)	50. 0	
	Hospital or 4 hours efte Funeral Dir tely filled in		29a, Certifier 1 Certifying Phys	ician: To the best of my kr	nowledge, dea	th occurred at the ti	me, date and pla	ce, and due to the	cause(s) and m	anner as s	stated.
	To the Hospital or Al within 24 hours effer of To the Funeral Direc completely filled in by	Medical	(Check only Dedical Examination)	ner: On the basis of examinand manner stated.	nation and/or i	nvestigation, in my o	ppinion, death oc	curred at the time,	date and place,	and due t	o the cause(s)
	To the Hospital within 24 hours e To the Funeral I completely filled	Me	29b. Signature and title of certifier			29c. Licens	Se number	28	29d. Date signed Mu-L	ed (Month,	Day, Year)
2			30 Name and address of person who co	moleted cause of death (Ite	3 S A	Print)	Rd	Clint	n Mi	0	20735
	St Regist	ate trar	31. Date filed (Month, Day, Year) MAR 3 0 2005	2. Registrar's Sig	nature	di.					
			1/11/11/11								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [12585 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Year If Inder 24
Days Hours 6. Sex **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 M 212 F Months Min Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or items 23a or 28e-f show freumatic event, the Medical Exame mr man be radified at 1 2 Yes 2 □ No Director Jairi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Black ò Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene. But: if item 27 is marked other then 5+ rechnol 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place) 0 DTEVERSVIlle trieno other 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it eny injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Funecal Service Licenses er/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTAT Physician 8 Man 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Physician/Medical Examiner Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ician and burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician sthe burial Box 68760. IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) P.O. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? Yes 2 No 2000 1 Yes 1 Tyes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 10 1 🗌 Yes No No 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 3□ DOA his 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: within 24 hours after dea To the Funeral Directo completely filled in by th 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check on Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month. Day, Year) 29b. Signature

DHMH 17 Rev 1/2001

State Registrar 30. Nime and address

31. Date filed (Month, Day, Year)

		•	•	tate of Maryland	d / Depa		lealth and N	Mental Hygi	9	12586
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	Physici		RALPH ANTHONY	GARNER				Month APRIL	1, 2005	10:35A M
	/Medio		4a. Facility Name (If not institution, give street			4b. City, Town, o	r Location of Death		4c. County of De	
			SOUTHERN MARYLANI	HOSPITAL		CLINT	ON		PRINCE	GEORGES
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
, pa	Director		2]8-20-0204 Usual Residence of Decedent 10a. State 10b. County	1 7 5	Yrs.					ARYLAND
N N	of show	tor	MARYLAND CHARLES			PLAINS				10d. Inside City Limits 1 ☐ Yes ⊅☐No
t d	128	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
W	23a c	alD	4784 SMITTY CIRC	LE		20	695		U.S.A	•
do a	SWe	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	lispanic Origin? (Span Mexican Puerto	pecify Yes or No-	14. Race - An Black, Wh	nerican Indian,
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De filed	al Hygi other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	laiden Sumame)	
2 5	marked o	ToE	JAMES ALEXANDER	GARNER			ELSIE	M. LAWS	ON	
Mar ytallu zizi	DE E		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State	, Zip Code)
	n 27		MILDRED M. GARNE					WHITE	PLAINS,	MD 20695
ָ ס	If Item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Pla oval from State	ace of Dispo metery, crei	sition (Name of matory or other place	ce)	Date 2	Oc. Location - City	or Town, State
	ortant: If It		`4 □ Donation 5 □ Other (Specify)	MARYLAN	D_VET	TERANS C	CEM. 4-6	5-05 C	HELTENH	AM, MD
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Ē.	8 K 5 3		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ions hat caused the death						Approximate Interval Between
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2	ures Isign Id be	d by	Cush	Sic An	m,	E7 ====		1 □ Ye	s 2 No 3	Probably 4 Unknown
	been si should I	lete	111 - 0	24/16	600	1		24a. Was ar	24b Were	autopsy findings available
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VICAL	artific ctor,	Be (25. Was case referred to medical examiner?	1			26. Place of Dea	th (Check only one	9)	
	his ca	2	1 ☐ Yes 2 Z No	1 ∠Inpatient 2 L	ER/Outpatie	and the second	4 Nursing H		nce 6 Other (Sp	pecify)
	Attending ringsicians redeath. ector: After this certifica by the funeral director.	on:	27. Manner of Death 1 2 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk?	28d. Describe ho	w injury occurred	
	leath lor: A the f	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	and 1 11 (m)		
DIVISION OF	s after d I Direct od in by	Certification:	4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify		reet, factory, office		City or Town	eet and Number or . , State)	Rural Route Number,
9	to the nospital of Attentioning Proysticant, to the Funeral Director. After this certific completely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying Physici (Check only one) Medical Examiner	an: To the best of my know: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the til evestigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
1	withir To th	Me	29b. Signature and title of certifier	1 016.	0.	29c. Licens		29	d. Date signed (Mo	nth, Dey, Year)
·	1		Menand	in the	and C	000	24208		4-2	-,05
11	1 N	P	30. Name and address of person who comp	pleted cause of death (Item	23a) (Type.	Printy 80	12600	De y	and R	Lef Ila
1	110		MBULLASAN	1 MNSN	21 6	W C	lihte	nik	20.00	2735
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ture	M. I		10		,
	Regist	rar	APR 1 2 2005	155 160 AS	100	The same of the sa				

			For State	Stare	of Marylar	-	artment of F		Mental H			
	Physicia	an	Registrar Decedent's Name (First, Midd				imodic or	Death	2. Date of Month	Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution		Hinckley	7	4b. City, Town, o	r Location of Dea		17, 200 4c. County		12.30 F M
	-Autilia		16384 Piney Po	oint Road			Piney 1	Point		Sain	t Mar	y's
	Funeral Director		5. Social Security Number 503-20-8265	6. Sex 1 ☐ M 2 ဩ F	7. Age (In yrs.	last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month,	Birth Day, Year) 28, 1930	Coui	place (State or Foreign ntry) aly
	p ,		Usual Residence of Decedent		10.0				ОССОВСТ	20, 1750		
	anylau show	<u>_</u>	10a. State 10b. County			ty, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2∑(No
	the M	Director	Maryland Sain 10e. Street and Number	t Mary's		Piney Po	int 10f. Zip Code			10g. Citizen of	What Cour	
	3a or	ā	16384 Piney Point	Dood								nuy:
	death ms 2	nera	11. Marital Status	12. Was De	cedent Ever in U	I.S. 13. \	2067 Was Decedent of H	lispanic Origin? (Specify Yes or		ce - Americ	can Indian,
2	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Indexted other then "neturel", or items 23a or 28e-f show imartic event, the Medical Evaluation used to indiffed at	by Funeral	1 ☐ Never Married 2 ☐ Mar 3 🖄 Widowed 4 ☐ Divorce	If Vac (2 ⊠ No Sive		fYes, specify Cuba 1⊠Yes 2⊡No	Specify	sian	Specif	ck, White, ^{fy:} Asi	
5	2 hor	Completed		nt's Education	4)	16a. Deced	lent's Usual Occup	ation		16b. Kind of B	lusiness/In	dustry
7	ithin 7	nple	Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	DO NOT use retired	d) most of w	orking			
7	led wi lygien her th it, the		12	(- A)		Но	omemaker			Own H		
2	l be fil ntal H ed otl	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Na		lle, Maiden Sumai	ne)	
Š	hould d Me mark matic	To	Unknown 19a. Informant's Name/Relation:	ship (Type Print)		19h Mailir	ng Address (Street	and Number or F	Unknown	nhar City or Town	State Zir	Codol
<u>0</u> ≅	nd 2 s lith an 27 is r treu		Joseph Suchinsky				Box 212, P				, State, 21 <u>,</u>	Code)
ָּטַ	s 1 av		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	20)	Date	20c. Location	- City or To	own, State
2	Page nert o nrt: If		1 ☐ Burial 2 XXCremation 1 ☐ Donation 5 ☐ 9ther (n State		n Crematory	- H	pril , 2005	Alexandr	ia. Vi:	rginia
Dallillor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Brown injury or other treumatic event, the Medical Example or usit to indiffer all some. Once.		21. Signature of Fune at Service	Licensee		Mat	Name and Addre	rdiner Fu	neral Hom	e, P.A.	, , , , , ,	
	¥ ×		23a. Part f. Enter the disease, o	r complications that	caused the dea		D. Box 270, er the mode of dyin					Approximate
	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause or		mun	ic (s	~ /	A 7	. 15.	Nor -	Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions, if any, leading to immediate	b. 2	o (or as a consec		s CE	con	در ۵۰	~	D'A	2002
Ī	and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	o (or as a consec							
0/00	cate be executed physician and the burial-transit	dicai E		d	, (0, 40 4 00, 100, 100, 100, 100, 100, 100	(do1100 01).						
		- w	IF FEMALE:	23c If yes c	utcome of pregn	2007						
	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	birth 2 ☐ Feta gnant at time of o	al death 3	Ectopic pregnancy Other (specify)	<u>'</u>	-		ite of delive onth	ery Day Year
cords, r	juires that signed b ild be deta	by	Part II. Other significant condit	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Di	d tobaceo use con Yes 2 □ No		he cause of death?
ว ว	2 2 2	Completed							24a. W	as an 24b.		psy findings available mpletion of cause of
	sicien: The lav certificate has rector, page 2	Con							pe 1□ Yes	rformed?	death? 1 🗌 Yes	
V 11.2	Physicien: r this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth	or	eath (Check onl	у оле)		
5	Phys rthis ral di	on; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	28a. Dat	Inpatient 2 e of Injury onth, Day Year)	28b. Time of Injury	I 3 DOA	4 🗀 Nursing		e how injury occur		y)
VISION	tendii leath. tor: A the fu	cati		igation and be			M 1 🗆	Yes 2 □No				
2	s after d s after d el Direct ed in by	Certification:		nined 280. Pla	ce of Injury - At h lding, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office		28f. Location City or 7	(Street and Numb Town, State)	ber or Rura	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel or the funerel	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To t Examiner: On the and ma	he best of my kno basis of examina unner stated.	owledge, death ation and/or inv	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the tim	ne cause(s) and m e, date and place,	anner as s	tated. the cause(s)
	To the within To the Comp	M	29b. Signature and title of certific	ar			29c. Licens		01-1	29d. Date signs	ed (Month,	Day, Year)
			30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Tvne		538	06 /	5/2	1/0	5
			Cindy R. Daly, M.				onardtown,	Maryland	20650			
ı	Sta Registr	_	31. Date filed (Month, Day, Year APR 1 4) 2.	Registrar's Sign							

			For Stete Registrar	State of	f Maryland	l / Depa <i>Cer</i>	rtment of H tificate of L	ealth and M Death		jiene () ()	5	12588
			Decedent's Name (First, Middle, Last)						2. Date of Dea	th		3. Time of Death
	Physici		John Gerard		Hod	dgson			Month March	26, 200	ear 5	5:35 P M
	/Medid		4a. Facility Name (If not institution, give s	treet and nun	nber)		4b. City, Town, or	Location of Death	~	4c. County of		
			6909 Keats Court				Derwoo	ođ		Mon	tgom	ery
	Funeral		Social Security Number 6. Sex		7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpla	ace (State or Foreign
	Director		577-40-8757	M 2□F	82	Yrs.	World Days	Tiodis IVIII.	Oct. 15	, 1922	Engl	and
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	ration				10	d. Inside City Limits
	sho sho ed ed	'n			loc. Ony,						10	1 ☐ Yes 2 █No
	15e N	Director	Maryland Montgom 10e. Street and Number	ery		Derwo	10f. Zip Code			Og. Citizen of Wh	at Caust	
	death with the Maryland rms 23a or 28a-f show		6909 Keats Cour	+			20855		'		_	-
	leath	Funerai			dent Ever in U.S.	. 13. V		spanic Origin? (Sp	acify Yes or No-		glan	
	r Itar	F	1 Never Married 2 Married	Armed For	rces? 2 ☑ No		Vas Decedent of Hi Yes, specify Cuba		Rican, etc.)	Black,	White, e	
215-0036	d within 72 hours after death with the Marylan jiene. Than "natural", or Itams 23a or 28a-f show than "natural" or Itams 23a or 28a-f show the Medical Esaminer must be notified at	by	3 Nidowed 4 ☐ Divorced	If Yes, Giv Year or Da		1	☐ Yes 2 No	Specify:		Specify:	Whi	te
ה ה	72 ho natur licel	Completed	15. Decedent's Educ (Specify only highest grade				ent's Usual Decupa kind of work done of		ina	16b. Kind of Busi	ness/Indi	ustry
N	within 72 ene. than "na'	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	OO NOT use retired,	bring most or work	"'g			
7	filed within the street of the street	Cor		4		Ow	ner/Opera			Travel		су
yland	be fil ital H id ott	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name		Maiden Sumame)		
Z Z	i Men Marke narke	မ	Hubert Hodgson	B 1 A					Barella			
Z Z	12 st hand 7 Is n traun		19a. Informant's Name/Relationship (Type Elizabeth Grinder		htor		g Address (Street a				ate, Zip (Code)
ტ —	Healt Healt Am 2		20a. Method of Disposition	, baug			Keats Co sition (Name of	1 1	Date	20c. Location - C	ity or Toy	vn State
وَ	de E de		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from S	State cen	netery, crem	natory`or other place an Cremator		h 30,			
baltimore,	it. Printme rteni njuri		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 1 cense	a //	1			- 1 20		Alexandr		Virginia
e E	permit. Pages 1 and 2 should be filed w Depurment of health and Mental Hygies Importent: If itam 27 is marked other it any niury or other traumatic avant. In		I you & x	scert	0	50	Name and Addres rancis J. O Univers	sity Blvd	, W, Sil	lver Spr:	nc ing,	MD 20901
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	ations that ca e cause on ea	aused the death. ach line.	Do not ente	er the mode of dying	, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	nysician :		Immediate Cause (Final disease or condition	Cere	brovascu	ılar A	ccident-A	cute				Onset and Death 3/20/05
	/Medical- Examiner		resulting in death)		or as a conseque		a 1.	7 D'				~1 .
		<u></u>	Sequentially list conditions, b		rioscier oras a conseque		Cardiovas	cular Di	sease			Chronic
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010 (or as a conseque	nied Oly.						
	xecu and	xar	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):		<u>-</u>				
8/60	cate be executed physiclan and the burial-transit	dicai										
9		edic										
ROX	death certiff e attending d for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23		come of pregnand		Catania aranga			23d. Date	of deliver	у
		icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of dea		Ectopic pregnancy Other (specify)			Month	1 [Day Year
5	at the by the	Physician/Me	9 Unknown									
Ś	requires that the death certifeen signed by the attending hould be detached for use a	by	Part II. Other significant conditions con				derlying cause give	n in Part I.		bacco use contrib		
ord D	w requir been s should	ted	Dementia, Peptic						1 U Ye	es 2 🛣 No 3	☐ Proba	bly 4 □Unknown
ပ္		Completed	Congestive Heart	Failur	e 				24a. Was a autops	sy pric	or to com	sy findings available pletion of cause of
	sician: The law certificate has l irector, page 2 s	Con							perform 1 ☐ Yes		ath?] Yes 2	2□ No
VItal	ician Sertifi ector	Be	25. Was case referred to medical examiner?	o anital:			0#-	26. Place of Deatl	n (Check only on	e)		_
0	this ald	10	1 Yes 2X No	ospital: 1 🔲 li 28a. Date d	npatient 2 Ef	R/Outpatient 8b. Time of	The same of the sa	4 🗆 Nuising no		ence 6 Other		
_	D e e	ion	1 Matural 5 Pending	(Mont	h, Day Year)	Injury	28c. Injury Work	es 2 No	∠8d. Describe no	ow injury occurred		
DIVISION	Attending of death. ector: After by the fune	lica	3 ☐ Suicide 6 ☐ Could not be	28e, Place	of Injury - At hom	e, farm, stre			28f. Location (St	reet and Number	or Rurai	Route Number
2	Dir Dir	Certification:	4 Homicide determined	buildir	ng, etc. (Specify)	-,	, , , , , , , , , , , , , , , , , , , ,		City or Town			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Hosp 4 hou Funa Funa lely fil	edical C	29a. Certifier (Check only one)	ician: To the er: On the ba and mann	isis of examinatio	iedge, death on and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occurr	and due to the cared at the time, d	ause(s) and manr ate and place, an	er as sta d due to t	ted. the cause(s)
	To tha within 2 To tha complet	Med	29b. Signature and title of certifier	and mail	custom	Α	29c. License	number	2	9d. Date signed (Month, D	ay, Year)
	/		MALLINA	frin	ILLMI	200	SMA	D23788		March	1 29	9, 2005
	>		30. Name and address of person who con	npleted caus	e of death (Item 2	23a) (Type, I	(Int)			110101		, 2000
_			Louise Stomierow				cutive Bl	vd, Rock	ville, N	1D 20852		
**	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 200	5 R	egistrar's Signatur	re	weed .					

			For State Registrar	Please	State of M		d / Dep		Health and I	•		e ₂₀₀	e.	12589
			1. Decedent's Name	e (First, Middle, La	ist)					2. Date of De				3. Time of Death
	Physici /Medio		Richard	E	Berry		Har	rison		March	26	-	ear	7:45P M
	Examin		4a. Fecility Name (f	f not institution, gi	re street and number)			4b. City, Town,	or Location of Death			. County of		1,451
			Civ	vista M	edical Ce	ente	r	TaP	lata			Char1		
	Funeral		5. Social Security N	lumber 6.	Sex 7. Ag		last birthday)	If Under 1 Year		8. Date of Bi	rth	9		ace (State or Foreign try)
	Director		116-26-57	728	1 % M 2□ F	6	9 Yrs.	Months Days	Hours Min.	tember				york
	ъ.		Usual Residence of	Decedent						00110002	.,			
	rylar	_	10a. State	10b. County			y, Town or L						10	Od. Inside City Limits
	e Ma	cto	Maryland	Prince G	eorges	Ac	cokeek							Y∏Yes 2 No
	or 21	Sre Sre	10e. Street and Nur					10f. Zip Code			-	itizen of Wha	at Count	try?
	death with the Maryland rms 23a or 28a-f show finust be rediffed at	Completed by Funeral Director	1725 Acc	cokeek Ro				20607			US	5A		
	r deg	ne	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U	.s. 13.	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No Rican, etc.)	0-	14. Race - Black.	America White, 6	
36	or i	Ϋ́		ied 2 Married	If Yes, Give	[№] 195	9	1 Yes 2 No				Specify:		
on 21215-0036	72 hours after natural, or ite dical Examen	d D	3 Widowed		Year or Dates:									
7	nat	ete	(Spec	15. Decedent's E cify only highest gr	ducation ade completed)		16a. Dece	dent's Usual Occu kind of work done	pation during most of wor ed)	king	16b. F	Kind of Busir	ness/Ind	lustry
12	within ene. than "	Ę	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	Super	Visor	na)		Fede	eral G	iove:	rnment
000	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the Me		12 17. Father's Name	/First Middle I as	*)				18. Mother's Nam	o /First Middle	Maida	- Cumama)		
J.	be f ad of	Be	Frank	S.	,	Harr	rison		Mabel		ros			
Harris Maryland	should be nd Mental s marked c	2	40- 1-4	/D-I-Nbis	(Torres Delen)		1 101 11-20		1					
Ha	12 st h an 7 is r		19a. Informant's Na			i fo			and Number or Ru Rd West				. ,	,
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Extra net must be rediffed at ance.		Audrey 20a. Method of Disp		arrison/ W		-	osition (Name of	. Ru west	-	_			
느	Pages nent of t int: if ite		1 🗀 Burial 2	☑Cremation 3 [Removal from State	0	emetery, cre	matory or other pla		Dat 2005		ocation - Cit		
time	tant tant			5 Other (Speci		Met			atory Apr	11 3,	ATe	kandri	.a, v.	irginia
i c	permit. Departn imports any inju		21. Signature of Fu		nsee	MC		2. Name and Addre	ess of Facility	D 7\ 7	Cura	eco N	tarv	land
~ •	00 = 0 O			issa O	fler							3604 6	ici y	- CINA
	Physician /Medical Examiner	iner	shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list confiant, leading to in cause. Enter Under Cause (Disease or that initiated events	(Final on	pplications that caused one cause on each life. Due to (or as b. Due to (or as b. Due to (or as	a country	uence of	ner						Interval Between Onset and Death
68760,	w requires that the death certificate be executed been signed by the attending physician and should be delached for use as the burial-transit	edical Examiner	that initiated events resulting in death) I	injury S Last	c. Due to (or as	a conseq	uence of):							
P.O. Box	requires that the death cert een signed by the attendin hould be detached for use	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? □ No	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□ Unknown	2 Feta	I death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of Month		ry Day Year
	that	by Pi	Part II. Other signif	ficant conditions	contributing to death t	out not res	ulting in the u	ınderlying cause gr	ven in Part I.	23e. Did	tobacco	use contribu	ute to the	e cause of death?
ds	uire n sign	d b	Hist	001	Prostal	e C	ancec	_		1 🗀	Yes 2	.□No 31	Proba	abiy 4 🗆 Unknown
Ö	law rec as bee	Completed		, ,	, ,					24a. Was	an	24h Wa	re autor	osy findings available
Re	The la cate has page 2	E								auto		prio	or to com	rpletion of cause of
a	n: Ti ficate or. pa		25. Was case refer		1					1 Tes	2 2 No) 1	Yes :	2 No
\ <u>\f</u>	Physician: The law this certificate has be al director, page 2 s	o Be	examiner?		Hospital:		50.0	Ot	26. Place of Dea					
of	Phy ald	H-	27. Manner of Deat		1 Impati		ER/Outpatie	III 3 DOX	4 Nursing H	ome 5 ☐ Resi 28d. Describe)
on	ding h. Afte fune	tlon	1 Natural	5 Pending	28a. Date of Inju (Month, Da	ıy Year)	Injury	Wo		200.000.00	non my	1, 00001100		
Division of Vital Records,	deat deat ctor: y the	Certification:	2 Accident 3 Suicide	6 ☐ Could not t	oe Diago of la	iury - At ho	ome farm st	reet, factory, office		28f Location /	Street a	nd Number	or Rumi	Route Number,
S	after Dire	ertii	4 Homicide	determined	building, et	c. (Specif	y)	reet, ractory, omce		City or To			or marar	riodia ricinibar,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exe	hysician: To the best miner: On the basis of and manner st	yt examina	wledge, deat	th occurred at the ti	me, date and place opinion, death occur	and due to the red at the time,	cause(s date an) and mann d place, and	er as sta due to	ated. the cause(s)
	To th withir Fo th comp	Me	29b. Signature and	title of certifier		1		29c. Licen	se number		29d. Da	ate signed (A	Month, L	Day, Year)
			1		~	In	1	D-0	0060456		-	3/2	71	05
(30, Nam and addr	ress of person who	completed cause of	death (Iten	n 23a) (Tyne					-1 -	. /	· _
D	8521		Dauod G	ith, Dav, Year)	mD 1134			oke Sq	Ste 104	Waldon	ſf,	MD 2	060	3
	Sta Registi	6		MAR 2 9	2005 32. Ryssti	Pose	D.	yparco						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 28, 2005 9:00 A M March Isabel Elizabeth /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery 321 University Blvd. West, #136 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 27, 1913 9. Birthplace (State or Foreign Country) Illinois 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2X F Yrs. 92 347-30-7852 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 28e-f show r than "natural", or Itema 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20901 321 University Blvd. West Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Business Owner permit. Fages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, Ing once. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Euler Henry Illig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6008 Bryn Mawr Avenue Glen Echo, MD 20812 Norman C. Bernhardt/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Marchate 29. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2005 Odenton, MD W. Arundel Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 ule MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METAGTATIC BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, phys IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 menths? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital To the Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D16619 2005 partical MD 30. Name and a criess of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MO. 21236 9940 FRANKLIN SOLLARE DRIVE C.VERGARA-SOARES 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature 3 1 2005

DHMH 17 Rev 1/2001

Registrar

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Registrar

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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra	,	20a. Method of Disposition 1 XBurial 2 ☐ Cremation : 1 4 ☐ Donation 5 ☐ Other (Spe	3 □Removal from State	20b. Place ceme	of Dispo	sition (Name matory or of cans C	ne of ther place	9)	Mar. 31 2005		20c. Locat	tion - City or 1	own, State
Balt	permit. Departi Import any inj		21. Signature of Funeral Service L	Bay		10	Name and East	d Addres De	s of Facilit		Gait	hersb	ome urg, M	d. 20877
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	5+1		30. Name and address of person w Dr. James Delve	cchio M.D.	1500 1	Fores	t Gle		ad S	ilver S	Sprin	g, Md	. 2091	0
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	e Hospital or Attending 24 hours after death. 9 Funeral Director: After etely filled in by the fune			ccurred at the time, date and place, a	and due to the cause	e(s) and manner as stat	ed.
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	W-3		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	int) A		+ 0 10	21043
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Frederick Michael Hewitt 03/30/2005 /Medical 0459 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 03/21/1950 Birthplace (State or Foreign Country)
 PA **Funeral** Days 1**X** M 2□F Months Hours Min 208-40-8230 55 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehov 1 ☐ Yes 2X No Director MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21 Robin Hood Trail 238 21811 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Medical Expuriner 1 Never Married Marned 5 Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No á 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important; if item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Company Service Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Kammer Hewitt ဥ Evelyn Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen M. Hewitt (Wife) 21 Robin Hood Trail Ocean Pines MD 21811

ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Ivy Hill Cemetery 04/06/2005 Philadelphia, PA 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William Street Berlin, MD 21811 3a. Part 1. Enter the disease, or complications the shock, or head failure. List only one cause tations that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Friysician HYPEKIENSIVE FELLY INEEKS resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) 82 3€ .0. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4□Pregnant at time of death signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 8 - 70 -Records, I 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 🗌 Yes Vital Physician: in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending Division 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pellil 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+ 203 OTHY 31. Date filed (Month, Day, Year) State MAR 3 1 Registrar

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Amended Item 17 per F.D. 04/05/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year John Joseph Harris 4:50 p[™] March 28 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Ctr Carroll Lutheran Village Health Care Westminster Carrol] 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**⊠**M 2□F Months Days Hours Director 218**-**18-3893 1924 Sept 30 MD Usual Residence of Decedent death with the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show Director 1 Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 St. Luke Circle 21158 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 19
If Yes, Give 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1943 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🛛 No Specify: Completed by If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 1946 naturel 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed w Health and Mental Hygier. tem 27 Is marked other th Financial Manager 4 Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fay Haris Fay Harris 2 Teresa Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Christina Sparr/daughter 306 Winsome Drive Hampstead, MD item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 tment of I 1 Burial 2 Cremation 3 Removal from State = 5 permit. Page Department o Important: If any injury or once. *4 □Donation 5 □ Other (Specify) Woodlawn Cemetery 4/1/2005 Woodlawn, MD 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21157 Approximate Interval Between Onset and Death corpostire Immediate Cause (Final Hemit **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ stenosis Herrento 1 Yes 2 No 3 Probably 4 Unknown Be Completed Res 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onli one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) replain DR, Hestminston MD21157 31. Date filed (Month, Day, Year) mn) 349 State MAR 2 9 2005 Registrar

DHMR 17 Hev 1/2001

		-	ForState		f Maryland / I	Depa		of H	ealth a	and M		401	15	1259	95
			Registrar 1. Decedent's Name (First, Middle	(last)		Cei	lincale	OIL	Jeani	1	2. Date of Death	g. No.		3. Time of Dea	
	Physicia										Month	Day	∕ear ⊏	10:15	
	_/Medic		Eleanor I. Ht 4a. Facility Name (If not institution		mher)		4h City T	Town or	Location of	of Death	March	26 200 4c. County o		10:12	Ρ
	Examin	er			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				inste			Carr			
_	Funeral		LookAbout Mar 5, Social Security Number		7. Age (In yrs. last bi	irthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth	1		lace (State or Fo	oreign
	Director		219-36-0051	1 □ M 2 □ 4 F	68	Yrs.	Months	Days	Hours	Min.	(Month, Day, March 2	28 1936	Coun	mD MD	17
	면 .		Usual Residence of Decedent												
	show	-	10a. State 10b. County	rroll	10c. City, Tow		ninste	ar.					1	0d. Inside City Li 1 ☐ Yes 2 ☐	
	88 -1	Director		FIOTT	70	esu									
	with ti		10e. Street and Number	-			10f. Zip		150		10	g. Citizen of Wh		try?	
	s 23s	eral	1510 Stone Road		edent Ever in U.S.	12.1	Mac Dood		158	ain? /Sna	oity Van ar Na	USA 14. Race		an Indian	
	item ineri	Funeral	 Marital Status Never Married 2 Marr 	Armed Fo	rces?	13.	If Yes, speci	fy Cubar	n, Mexicar	, Puerto	ecify Yes or No- Rican, etc.)		White,		
99	al', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	/8		1 ☐ Yes 2	2 ∑ No	Specify:			Specify:	Wr	ite	
ŏ	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-1 show the Medical Exertii et frast be retiffed at	Completed	15. Deceden	t's Education	16a	. Dece	dent's Usual kind of won	I Occupa	ition	A = A	1	6b. Kind of Bus	iness/Inc	lustry	
215	e. en "r	pe	(Specify only highes Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.	DO NOT us	e retired)	uning mos	t of works	ng				
7	filed will Hygien ther th ent, the	Son	12				Clear					Janito			
nd	be filed ital Hygie od other event, I	Be	17. Father's Name (First, Middle,								(First, Middle, N)		
$\frac{8}{2}$	should and Men a marke umatic	은	William Jacob		700		V	(0)			Fleischm				
Maryland 21215-0036	d 2 sh h and 7 Is n traun		19a. Informant's Name/Relations Robert Humbert				-				Nestmin Westmin	-		21157	
	1 and Health em 27 sther tr	1	20a. Method of Disposition	DICCIOL	20b. Place of cemeter						_	Oc. Location - C			
2	Pages nent of int: If it		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Pleas						/2005			lley, M	TD.
Baltimore,	그 등 원 등	1	21. Signature of Funeral Service		Fleas			_		_				LICY / 12	
ä	permi Depar Impo any ir		VV.201	ullst	5	1	Pritts	s Fur	neral	Hom	e and Ch	apel, P	'.A.	21157	
			23a. Part1. Enterne disease, or	complications that	aused the death. Do	not ent	er the mode	aSn LI e of dying	g, such as	cardiac c	respiratory arre	st,	IVH	Approximate Interval Between	20
	Enysician :		shock, or heart failure. List Immediate Cause (Final	MD-	astatio		CO	lm	A	CA	A			Onset and Deat	
	/Medical		disease or condition resulting in death)	a. Due to	(or as a consequence	of):							-	1/24	W
П	Examiner		Sequentially list conditions	b											
7	p #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consa uence	of):							1		
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c.	(or as a consequence	of):									
760,	icate be executed physician and s the burial-transit	calE	J ,		(or as a consequence	01).									
687	phys phys s the			d											
×	certif nding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy							23d. Date	of delive	rv	
Вох	death a atter	ciar	in the past 12 months?	4□Pregn	oirth 2 ☐ Fetal death nant at time of death		⊒Ectopic pre ☑ Other (spe					Mont	h	Day Year	r
o.	t the c	hys	9 □ Unknown	9□ Unkn	own										
o,	The law requires that the death certifica ate has been signed by the attending phrage 2 should be detached for use as the	by P	Part II. Other significant condition	ons contributing to de	eath but not resulting	in the u	nderlying ca	ause give	n in Part I		23e. Did tob	acco use contrib	ute to th	e cause of death	h?
ğ	w require been sig should b	ed									1 □ Ye	s 2 ⊡/No 3	Prob	ably 4 □Unkn	nown
ecc	e law n has be je 2 sh	ple									24a. Was an		ere auto	osy findings avai npletion of cause	lable e of
<u> </u>		Completed									perform 1 ☐ Yes 2	ed? de	ath?] Yes	21 No	
of Vital Records,	Attending Physician: The sr death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medica examiner?					- 0.1		of Death	(Check only one	,)	·	Assiste	ക്രീ
7	Physic this c	7	1 Yes 2 No		Inpatient 2 ER/O			-	4 - 140		me 5 Resider		(Specify	Living	Cu
NC On O	ding Ph h. After th funeral	lon	27. Mann of Death 1 Natural 5 Pendir	ig .		Time o	M	8c. Injury Work 1 □ V	ai ? ∕es 2 🔲	- 6	28d. Describe ho	w injury occurred	,	-	
Division	death death ctor:	ficat	2 Accident investi 3 Suicide 6 Could	not be 200 Place	of Injury - At home, f	arm, str				-	28f. Location (Str	eet and Number	or Rum	l Route Number,	
<u>S</u>	after after Dire	Certification;	4 ☐ Homicide determ	buildi	ing, etc. (Specify)		,,	,			City or Town,	. State)			
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical C	(Check only 2 Medical	Examiner: On the b	best of my knowledg	je, deat nd/or in	h occurred a	at the tim	e, date an	d place,	and due to the ca ed at the time, da	use(s) and mani te and place, an	ner as st	ated. the cause(s)	
	the the the mplet	Med	29b. Signature and title of certifie	1	ner stated.		29c.	. License	number		29	d. Date signed	(Month,	Day, Year)	
	F3F8		MILLIA	Kunler	MIS		D	35	30	12		3-28			
1	My Wit		30. Name and address of person	who completed caus	se of death (Item 23a)	(Type.				, —		-	7	/	
(NY "		Flaviorniteck	mi 555	South			112	astro	127.11	er HiD	21157			
	2]								$\Gamma \cup \cup \Gamma$	W I PIO	3			
* 1	Sta Registr		31. Date filed (Month, Day, Year)	32. F	Registrar's Signature	L			<u> </u>	الركاا	et PIO	3 1.3 1			

State of Maryland / Department of Health and Mental Hygieng U U 5 1 - State Registra Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Month March 25, ^{Day} 2005 **Physician** А м 4:30 Lillian Mildred Ingels /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Village Health Care Montgomery Village If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🗓 X F Director 80 083-18-6613 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State works 77 is marked other then "naturel", or items 23e or 28e-f shov treumetic event, its Marked Examinet in using the mailined at 1X Yes 2 □ No Director Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 20886 19310 Club House Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 C∏No If Yes, Give Year or Dates: 1945–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc e filed within 72 hours after on the filed within 72 hours after on the file of the file o 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland Elementary/Secondary (0-12) College (1-4or 5+) State Government 12 Secretary 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi and Mental F 1s marked of Ellen Frederickson August Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 23626 Overlook Park Drive Clarksburg, MD 20871 David B. Ingels/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite any injury or ot once. 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gardens `4 ☐ Donation 5 ☐ Other (Specify) 3/30/2005 Davidsonville, MD 21. Signature of Suneral Service Lice 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician a Acute Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Undersing Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events death certificate be executed use as the burial-transit Recent M ocardial Infarction and resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medicai Anemia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. I the detached 9 Unknown cate has been signed by i page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Diabetes Mellitus 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hyperlipidemia autopsy performed? certificate 2 💢 No 1 ☐ Yes Division of Vital Physicien: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 🙀 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending Pl24 hours after death.Funerel Director: Atter ti Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a To the Funerel D 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 D41162 March 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19525 Doctor's Drive Germantown, MD 20874 Vinu Ganti MD State MAR 28 2005 Registrar

			For State Registrar	State of Maryla		artment of F		lental Hy	71111	5 1259
			Decedent's Name (First, Middle, Last)				Doui	2. Date of De	Reg. No.	3. Time of Death
	Physici		Doris Jeffers	on				March	27, Day 2005 Ye	6:00 a
	/Medic Examir		4a. Facility Name (If not institution, give s Heartland Nursing			4b. City, Town, o	r Location of Death		4c. County of D	
	Funeral Director		5. Social Security Number 6. Sex 577-68-6540	X	rs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month Da April	23,1950 9.	Birthplace (State or Forei Country) Georgia
	pu .		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	cation				10d. Inside City Limi
	Maryli sho	ō	Maryland Prince Ge		pitol H					1√T¥es 2□N
	r 28a-	rect	10e. Street and Number	orge of	preor n	10f. Zip Code			10g. Citizen of Wha	
	th with	aiD	907 Sitka Lane			20743			United St	ates
õ	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exart art must be notified at	/ Funeral Director	1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 24 No If Yes, Give]	Was Decedent of Hilf Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Black, V	American Indian, White, etc.
Š	ural',	q p	3X Widowed 4 □ Divorced	Year or Dates:						Black
9500-6121	vithin 72 ne. han "nat	Completed by	15. Decedent's Edu- (Specify only highest grade Elementary/Secondary (0-12) 11th	cation a completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of worki	ing	16b. Kind of Busin	
N	filed within Hygiene. Ither than "	CO	17. Father's Name (First, Middle, Last)		Manag	er	18. Mother's Name	(First, Middle	Maiden Sumame)	Industry
Maryland	should be ind Mental simarked o	To Be	Otis Whitaker	0: "			Hattie	Mae	Thomas	
	and 2 sealth an n 27 is		19a. Informant's Name/Relationship (Ty, Candace Brewington	/ Daughter	907 S	itka Lane	e Capitol	Height	er, City or Town, Sta	nd 20743
Baltimore,	permit. Pages 1 Department of H Important: If iten any Injury or oth		20a. Method of Disposition 1 □ Burial 2XXCremation 3 □R 1 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crei	osition (Name of matory or other place tan Crema	atory 3-30	0ate 0-05	20c. Location - City Alexandr:	y or Town, State ia, Maryland
Ball	permit. Departr Importu any inji		21. Signature of Funeral Service License	Mos) Å	Name and Addre lexander 538 Marlb	ss of Facility S. Pope I	Tuneral Forest	Homes ville, Md.	20747
	Physician /Medical Examiner		23a. Part 1. Inter the disease, or complishock of heart failure. List only or Immediate Vause (Final disease or condition resulting in death)	cations that baused the die cause on leach line. Atheroscle: Due to (or as a cons	rotic He			or respiratory a	errest,	Approximate Interval Between Onset and Death
08/60,	icate be executed physicien and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons						
O. Box 68	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preduction of the second of the se	etal death 3	□Ectopic pregnancy			23d. Date of Month	f delivery Day Year
7	uires that signed b d be deta	b	Part II. Other significant conditions cor End Stage Renal Di							te to the cause of death?
Vital Records,	e law require has been sig e 2 should b	Completed	Depression, Corona	ry Artery D	isease			24a. Was	psy prior	e autopsy findings availab
<u></u>	hysician: The law his certificate has t I director, page 2 s							1 ☐ Yes	ormed? deat 2 No 1 □	
=	siciar	Be.	25. Was case referred to medical examiner?	lospital:		oth	26. Place of Death			
on or	ding Phys h. After this funeral di	tlon: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatier 28b. Time o Injury	f 28c. Injur	4 Washursing Hol		idence 6 Other (Specify)
DIVISION	or Attencater death Director: in by the	ertificat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)				(Street and Number own, State)	r Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical Co	29a. Certifier 14 Certifying Phys. (Check only one) 2 Medical Examination	sician: To the best of my liner: On the basis of exame and manner stated.	knowledge, deat ination and/or in	h occurred at the tirvestigation, in my o	me, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	Fo the within Fo the	Med	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (M	fonth, Day, Year)
			Mars 7	Tahl En	rlas	n 000	158776		3/2011	15-

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 3 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Doris V. Paldo-Bustos 106 Irving St. Suite 411 Washington, DC 20010

Amend item/PII, C842, 412/05 III State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Beverly R. Jones 2005 Mar 28, 1:46 a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 923 Heatherfield Lane Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Days 1 □ M 2 🕱 F Yrs. MI Director 371-34-4820 69 31, 1935 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State s 23a or 28a-f show ust be notified at 1 ☐ Yes 2 No MD Anne Arundel Millersville Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 923 Heatherfield Lane 21108 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 No White ō 1 ☐ Yes 21 No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic avant, the Medical Elementary School than Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher and Mental Hygie is marked other 1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Neil Doxsee Runciman Muriel Beatrice Mulholland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trau 923 Heatherfield Lane, Millersville, MD Paul A. Jones/Husband 21108 Mar. 25 2005 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Baltimore, MD Metro Crematory '4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Ineral Service licens Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 of t. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death m ediate /ause (Final risease or condition resulting in death) HUNGINTON'S CHOREA one Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Useass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown à signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ρ 20010 3 Probably 4 Unknown 1 🗌 Yes funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 25 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home ome 5 Residence 6 Other (Specify)
28d. escribe how injury occurred 1 ☐ Yes 2 No Certification: To this 27 Manner of Jeath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my клоwledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29c. License number 29d. Day's signed (Month, Day, Year) 29b. Signature and title of 30. Nam and address of erson who completed cause of death (Item 23a) (Type, Print) 21401 0 2014 Ext MO 400 strar's Signature 2003 31. Date filed (Month, Day, Year) 2005 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 2005 29 March 7:30 A M Jeanette Kramer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 13,1941 9. Birthplace (State or Foreign Country) N. Carolina 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛣 F 240-62-4761 64 Yrs. N. Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "neturel; or itams 23a or 28e-f show any injury or other traumatic event, the Marical Eventine must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Crofton Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1927 Harcourt Ave. 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Analyst Nat. Security Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martha Grady Brownlow Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1927 Harcourt Ave. Crofton, MD. Wayne R. Kramer / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 03/30/2005 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy. Bowie, MD. Fue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Respira /Medical Due to (or as a consequence of). Examiner Neumer, A Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Due to (or as a consequence of): Examiner cause (Disease or injury death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial P.O. Box 68760, Physiclan/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached t Yes 2. No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 TYes Il or Attending Physicien: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Inpatient 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 100576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 medica im woons 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2005 Registrar

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			Registrar Decedent's Name (First, Middle, Last	st)		rincare	01 00	Catif	2. Date of Death	g. No.		3. Time of Death
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Maryland	should nd Men marka imaric	P_	19a. Informant's Name/Relationship (7		19b. Maili	na Address (S	Street and		al Route Number,	City or Town	State Zin	Code)
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 25, 2005 1:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□F Months Days Hours Yrs. Director 226-25-7806 83 AUG. 20,1921 VIETNAM Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No SILVER SPRING MONTGOMERY MD. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 or Items 23s 20905 6 FAIRDALE CT. U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status il Hygiene. Il Hygiene. other than "natural", or Item Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced **ASIAN** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ARMED SERVICEMAN VIETNAM MILITARY s 1 and 2 should be filed of Heelth and Mental Hygis item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PHAN LUC NGOC-ANH 2 T. NGUYEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUC/DAUGHTER PHUONG-VAN 6 FAIRDALE CT., SILVER SPRING, MD. 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
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Important: If itel
any injury or oth 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD. CHAMBERS CREMATORY 3-31-2005 CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. RU M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician LUNG CARCINOMA WITH METASTASIS /Medical Due to (or as a consequence of): Examiner FAILURE TO THRIVE Sequentially list conditions if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed use as the burial-transit **ASTHMA** that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☐XNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification; Injury at Work? After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check on one) within 2 the 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) 25/ 7001 MIMADIE D59284 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID M.D. 1500 FOREST GLEN RD., SILVER SPRING, MD. 20910 SHAMIM, 31. Date filed (Month, Day, Year) MAR 30 2005 Registrar

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ath cartifi ttending	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	gnant iths?	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic p						23d. Date of Month	delivery Day Year
w requires that the de been signad by the a should be detached f	b	Part II. Other significan	t conditions con	tributing to death b	ut not resu	ılting in the ur	nderlying o	ause give	n in Part I.			obacco u Yes 2		e to the cause of death? Probably 4 _Unknown
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I or Attending Physicien: The after death. Director: After this certificate his in by the funeral director, page	tion: To Be	25. Was case referred examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 2 Accident	1	ospital: 1 ☐ Inpatie 28a. Date of Injui (Month, Day	v	ER/Outpatien 28b. Time of Injury		8c. Injury Work	r. 4 □ Nur	sing Home	5 Resid. Describe	dence	G SpOther (≨ y occurred	ਬπddaughte House
Hospital or Attending 14 hours after death. Funeral Director: Afte tely filled in by the fune	Certification:		Could not be determined	28e. Place of Injubulding, etc	ury - At ho c. (Specify	me, farm, str	eet, factor	y, office		28f	Location (City or To	Street an wn, State	d Number oi)	r Rural Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 (Check only 2 one)	Certifying Phys Medical Examin	ician: To the best of ter: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred restigation	at the time , in my opi	e, date and inion, deat	d place, and h occurred	d due to the at the time,	cause(s) date and	and manner place, and	as stated. due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title	of eartifier				29	c. License					,	onth, Day, Year)
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	State strar	30. Name and address Barbara Co 31. Date filed (Month, D	ooper, AR 3 0 20	M.D., I1	nter	nal M	ledic	ou We	est And	rerii rews	neter AFB,	Ma	rylan	d 20762

				artment of Health and Me	ntal Hygier	211115	12606
,	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) Thowas Lapallo . Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	03	Day Year 23 2cos 4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 179-14-1802 1XIM 2 F 84 Yrs.	Baltywove If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. C	Date of Birth (Month, Day, Yea)2-20-192	9. Birti Co	hplace (State or Foreign untry) PA
	Maryland a-f show iffied at	tor	10a. State 10b. County 10c. City, Town or Lo	Glen Burnie			10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23e or 28	al Director	10e. Street and Number 634 Baylor Road	10f. Zip Code 21061	10g. (Citizen of What Co USA	untry?
3-0036	72 hours after death with the Maryland Instural; or Itams 23e or 28e-1 show Ites Examination and be mailtied at	by Funeral	1 Never Married 2 Married 1 XYes 2 No WW↓↓ 3 Widowed 4 Divorced 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Rik 1 ☐ Yes 2 ☒ No Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
7-61212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23e or 28e-f show amy injury or other traumetic event, Ite Marical Examinet must be notified at ODGe.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Completed Own	dent's Usual Occupation kind of work done during most of working DO NOT use retired) IET/Operator	T	Kind of Business/I homas Clo n Odentoi	othiers
yland	ould be file Mental Hy arkad oth	To Be	17. Father's Name (First, Middle, Last) Anthony La Pallo	18. Mother's Name (f Josephine		•	
, Mar	and 2 sho salth and 1 27 is mu ar traume			ng Address (Street and Number or Rural F Baylor Road, Glen E			lip Code)
pairimore	Pages 1 and the note of He int: If item			matory or other place) Mar.	25	Location - City or 1	
Dail	permit. Departn Importa any inju			Sarranco Address of Facility, P.A. 195 Gov. Ritchie Hwy			
,	Physician /Medical Examiner transit the prinal-transit the prinal-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death
O. DOX 00/00,	the page	Physiclan/Medical		Ectopic pregnancy Other (specify)		23d. Date of deliment	very Day Year
r (spins)	juires that signed to lid be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the un	ndertying cause given in Part I.	1.		the cause of death?
ב כ	n: The law rec licate has bee r, page 2 shou	Completed	Respiratory failure		24a. Was an autopsy performed?	prior to c death?	opsy findings available omptetion of cause of
Vision of Vital	To the Hospitel or Attending Physicien: The law requires that the death cer within 24 hours after death within 24 hours after death. To the Lunarel Director After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Certification: To Be	25. Was case referred to medical examiner? 1 Yes	28c. Injury at Work? M 1 Yes 2 No	5 Residence	ury occurred	
2	To tha Hospitel or Attandi within 24 hours after death. To tha Funarel Diractor: A completely filled in by the fu		29a. Certifier (Check only (Ch	n occurred at the time, date and place, and	I due to the cause/	s) and manner as	stated.
	To tha H within 24 To tha F complete	Medical	29b. Signatuse and title of gentities and manner stated.	29c. License number	29d. D	ate signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print) AU4176435 Of Maryland Medi	3/	23/2003	
	⁵ ′ Sta		31. Date filed (Month, Day, Year) 32. *** 32. **** 32. ******************	of Maryland Medi	cal center	V, Baltu	nove
	Registr	ar	MAR 2 8 2005				

Nico Lee 05-2284 AKG

> Physici /Medi Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Items 23a or 28a-1 show any injury or other traumatic event, the Mcdical Examiner must be notified at once.

Pnysician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

POLOGODIII 2 IAGIIIA	(First, Middle	, Last)			rtific@5				2. Date of De	Reg. No. ath		3. Time o	f Death
	Nico	Caleb Lee							Month March	Day	2005	12:5	2 p
a. Facility Name (If	not institution	, give street and num	ber)		4b. City,	Town, or	Location	of Death	TIGE		County of Deat		<u> </u>
Prince:Ge	orge's	Hospital	Center		Che	ever1	У				Prince	e Georg	e's
Social Security Nu		6. Sex 7	. Age (In yrs. la		Months	r 1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da	y, Year)	Co	hplace (State ountry)	or Fore
216-71-08		IEM ZUF		Yrs.	3	25		ţ	ec. 4,	2004	Mary		
sual Residence of I	10b. County		10c. City,	, Town or Lo	ocation							10d. Inside C	ity Limi
Maryland	Princ	e George	Capit	tol He	eights	5						1 ☑ Yes	2 🗆 N
De. Street and Num	nber				10f. Zip					10g. Citiz	en of What Co	untry?	
737 Cap	ital H	eights Blv	7d.				207	43		Unite	d Stat	es	
1. Marital Status		12. Was Deced	dent Ever in U.S	3. 13.	Was Deced	dent of Hi	spanic Or	igin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, White		
1 Never Marrie			21⁄2 No	1	1 Tes		Specify:		mount, orang	1		lack	
3 Widowed		Year or Da											
	15. Decedent ify only highes	t grade completed)		(Give	edent's Usua e kind of wo DO NOT us	ork done a	turing mos	t of workir	ng	16b. Kin	d of Business/	Industry	
Elementary/Secon	ndary (0-12)	College (1-	4or 5+)	<i>iii</i> 0.	N/A						N/A		
7. Father's Name (/	First, Middle,	Last)	<u>I</u>		-1/ 1.		18. Moth	er's Name	(First, Middle,	Maiden S			
Felix B	Boateng							Ange1	a Lee				
9a. Informant's Na	me/Relations	hip (Type, Print)		19b. Maili	ing Address	s (Street a	and Numb	er or Rura	i Route Numbe	er, City or	Town, State, 2	Zip Code)	
Angela L	Lee/Mot	her		737 0	Capita	al He	ight	s Blv	d.; Ca	pita1	Heigh	ts,Md.	20
0a. Method of Disp			20b. Pla	ace of Dispo	osition (Nar	me of other place	9)	D	ate	20c. Loc	ation - City or	Town, State	
1 丛 Burial 2 ∟ `4 □ Donation		3 □Removal from S oecify)	lale I					pril	9,2005	Sui	tland,	MD.	
21. Signature of Fur	neral Service	Licensee	10108	2:	2. Name an	nd Addres	s of Facili		ope Fur 538 Mar orestv			20747	
Part Falanth	1007	ourg that an	uned the death					r	orestv	шe.	MO.	20/4/	
mmediate Cause (fisease or condition esulting in death)	Final n	Due to (c	e Bronch	nopneu ence of):					r respiratory ar	rest,		Approxima Interval Bet Onset and	ween
disease or condition esulting in death)	Final nditions, mediate rlying injury	a. Acute Due to (c	Bronch	nopneu ence of):					r respiratory ar	rest,		Interval Bet	ween
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DHMH 17 Rev 1/2001

St. Regist

			1 - For State Registrar		Marylan	-	artmen rtificate			and M	-	giene Reg. No.	005		2608
	Physici /Medi		Decedent's Name (First, Middle ESTHER MIRIA)	M LEVAN							2. Date of De Month March	ath Day	200 ⁹	ar	3. Time of Death 1:59A. M
	Examir		4a. Facility Name (If not institution HOLY Cross Hosp.	, give street and num ital	nber)				Location of Sprin				County of D	Death	
	Funeral Director		5. Social Security Number 267–41–5926	6. Sex 1 ☐ M 2√2 F	7. Age (In yrs.	last birthday) 99 Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da March5	th y, Year)	9.		e (State or Foreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	e George's		y, Town or Lo	ocation								Inside City Limits 1 ☐ Yes 2 ☑ No
	with the Page or 28a-	I Director	10e. Street and Number 12601 Cedarbroo	ok Lane			10f. Zip		0708			_	en of Wha	t Country?	?
920	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show calcal Exacuter must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 XWidowed 4 Divorced	12. Was Dece Armed For ed 1 Tyes If Yes, Giv Year or Da	е -		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)		4. Race - /	American I Vhite, etc.	
Maryland 21215-0036	3 within 72 ho plene. r than "natur Ir e Madical I	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12		4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done c	turina most	t of workir	ng	16b. Kir	nd of Busine	ess/Indust	try
and 2	d be filed wantal Hygle ced other to	Be	17. Father's Name (First, Middle, Samuel		ayor	house	ewife		18. Mothe	er's Name	(First, Middle,	Maiden	n hom Sumame) urste		
	nd 2 shoul ilth and Me 27 is mark r traumati	To	19a. Informant's Name/Relationsh Robert Levan –s	nip (Type, Print)		19b. Mailir 12601	ng Address Ceda	(Street a	ook La	ar or Rura. Ane I	Route Number	er, City or	Town, Sta	te, Zip Co	de)
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked othar any injury or other traumatic event.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Se		State Old	Place of Dispo emetery, cres Monte	osition (Name matory or ot Efiore	ne of ther place Cen	etery	о у 3/2	ate 29/2005	20c. Lo	cation · City	or Town, New	State York
Balti	permit. I Departm Importa any inju		21 Signature Fiberal Service	Mouk	n e		Name and P	d Addres V OW Ö E	s of Facility Borgu	yardt Vardt Ko	Funer ad Bei	al Ho Esvi.		PA Maryl	and 20705
	Physician /Medical		23a. Part1. Enter fine disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Seps:	ich line. LS			of drying	g, such as	cardiac of	r respiratory a	rrest,		Int	proximate erval Between iset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate bases. Exact vicertying Cause, (Disease or injury	b	or as a consequence P	uence of):									
8760,	cate be executed oblysician and the burial-transit	dical Examiner	cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq		ccide	nt ——							
.O. Box 68	death certifi e attending I id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pre					2	3d. Date of Month	delivery Day	y Year
S, D	w requires that the been signed by th should be detache		Part II. Other significant condition Dementia; Hypot	ns contributing to de Chyroidism	ath but not res	ulting in the u	nderlying ca	iuse give	en in Part I.		23e. Did t				ause of death?
Vital Record	The law ate has b page 2 sl	Completed by									24a. Was autop perfo 1 □ Yes		24b. Were prior death	to comple	findings available ation of cause of
of Vita	S S	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo		_	ER/Outpatier		A Othe	9r: 4 □ Nur	rsing Hom	Check onli	dence 6		Specify)	
Division	To the Hospital or Attending Physician: within 24 hours alter death. To the Funatal Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation ot be	f Injury n, <i>Day Year)</i> of Injury - At ho	28b. Time of Injury	М		at ? ∕es 2 □ N	No	8d. Describe I			r Pum/ Po	nuta Alumbas
Δi	pital or A burs after aral Dirac filled in by		4 Homicide determi	Physician: To the	g, etc. (Specify	y)			a data and		City or Tov	vn, State)			
	To the Hospital or within 24 hours after to the Funeral Dirac completely filled in It	Medical	(Check on) 2 Medical B	examiner: On the ba	sis of examina	tion and/or in	vestigation,	in my op	inion, deat	h occurre	d at the time,	date and	place, and	due to the	cause(s)
			1 5-	SAMIN	1			5928	number 34			3	28	120	05
	13		30. Name and address of person vehicles Shahid Shamim,	M.D. 1500	Forest	Glen	Road	Silv	er_Sp	oring	, Mary	land	20910)	
	Sta Registr		31. Date filed (Mooth, Day, Yzr)	2005 32.	gistrar's Signa	J. A	oseli	,							

			1 - For State Registrar		Maryland /		artment of H rtificate of L		and M		نـــ. Reg. No.		1260	09
۱	Physici	an	Decedent's Name (First, Middle,		1					2. Date of De Month	Day			Death M
j	/Medio		Jennifer 4a. Facility Name (If not institution,	Kay Lus give street and numb			4b. City, Town, or	Location of		March 2		005 County of Dea	1257	141
	- Zamini	Ψ'	Peninsula Regio	nal Medica	1 Center		Salisbu	сy			W	icomic	0	
	Funeral			6. Sex 7. 1 ☐ M 2 1 F	Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Bi	rthplace (State or country)	Foreign
	Director		204-56-5851 Usual Residence of Decedent	7	35	115.				11-16-	1969	Pe	nnsylvan	ia
	nyland how		10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City	
	8a-f s	Director	MD Somer	set	Mari	on S	Station						1 Yes	2 🗌 No
	with ti		10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What C	ountry?	
	death	Funeral	30371 Marumsco	12. Was Decede	ent Ever in U.S.	13.	21838 Was Decedent of Hi If Yes, specify Cuba		gin? (Spe	cify Yes or No	- 1	USA 14. Race - Am	encan Indian,	
ဖွ	or ita	/ Fur	1 🗆 Nøver Married 🛮 2 Marrie	Armed Force od 1 Tyes 2 If Yes, Give	es? No		if Yes, specify Cuba 1 □ Yes 2 2 No	n, Mexican Specify:	i, Puerto I	Rican, etc.)	1	Black, Whi	ite, etc.	
Ö	filed within 72 hours after death with the Maryland Hygien. Ither than "natural; or Itams 23a or 28a-f show ant, I'lis Meulcal Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Date	PS:								White	
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n D	be file ital Hy id oth evant	Be	17. Father's Name (First, Middle, L	ast)				18. Moth <i>e</i>	r's Nam <i>e</i>	(First, Middle,	Maiden .	Sumame)		
<u>\Z</u>	should Ind Menion Menio	မ	Robert Bowers 19a. Informant's Name/Relationsh	in (Tuno Brint)	10	the Admitte	Add (Ctt-	Faye	Balt	haser	0:	T 0		
<u>8</u>	nd 2 s ilth an 27 is i		Jeffrey Lee Lu		3	0. Maiii 0.371	ng Address (Street a	Roac	d. Po	Box 3	35. 1	Marion	Station	38 . MD
J.	of Hea		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place	T		ate		cation - City or		, 112
Ĕ	Pages ment of I ant: if its ury or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	ecify)	1(0)	-	Cemetery	1	03/29	9/2005	Prin	cess Aı	nne, MD	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the 27 is marked other than "natural," or flams 23a or 28a-f show eny injury or other traumatic evant, I in Madical Examinating its political at once.	1	21. Signatura of Funa al Service L	(heart)		22 H i	. Name and Addres .nman Fune	s of Facility	y					
	45	7	29a. Part 1. Enter the disease, or o	omplications that cau	M00295 sed the death. Do	111	673 Somer	set A	Ve.	Prince	ess A	Anne, M	D 21853 Approximate	
	Tiysician	A	Immediate Cause (Final	nly one cause on eac	h line.								Onset and De	
	/Medical	W	disease or condition resulting in death)	Due to (or	as a consequence	ntra of):	avascular	Coag	u Lopa	athy				
	Examiner	_	Sequentially list conditions,	b. Post p	artum he	morr	hage							
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Eug to (or	as a conseduence	ot).								
oʻ	an and rial-tra		that initiated events resulting in death) Last	Due to (or	as a consequence	of);								
8760	rate be executed hysician and the burial-transit	dicai		d										
X	eath certific attending p	/Med	IF FEMALE:	23c. If yes, outcome	me of pregnancy							0d D-1(d-	P	
ğ.	atte	Physician/Me	23b. Was decedent pregnant in the past 12 months? ∑Yes 2 □ No	1. Live birth 4. Pregnan	2 ☐ Fetal deat t at time of death		Ectopic pregnancy Other (specify)				2.	3d. Date of de Month	Day Ye	ar
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ecords, I	taw requires that the as been signed by the 2 should be detache	by	Part II. Other significant condition	s contributing to deat	h but not resulting	in the ur	nderlying cause give	n in Part I.			obacco us /es 2		o the cause of dear	
Y	The ate h page	Completed								24a. Was autop perfor 1 Tes	sy	24b. Were as prior to death?	utopsy findings av completion of cau a 2 No	ailable ise of
Vital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only o				
	Phys or this oral dir	1: To	1 ☐ Yes 2⊠ No 27. Manner of Death	28a. Date of I	njury 28b.	utpatien Time of	28c. Injury	at		ne 5 ☐ Resid 8d. D <i>e</i> scrib <i>e</i> h			cify)	_
0	Attending I ir death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	Work	? ′es 2 🗍 N						
	i Sir e	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place of	Injury - At home, f etc. (Specify)	arm, stre	eet, factory, office		2	8f. Location (S City or Tox	Street and m, State)	Number or R	ural Route Numbe) <i>Г</i> ,
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the be xaminer: On the basis and manner	s of examination a	je, death nd/or inv	occurred at the time restigation, in my op	e, date and inion, deat	d place, a h occurre	nd due to the d d at the time, d	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)	
	To T To T	Σ	29b. Signature and title of certifier				29c. License				29d. Date	signed (Mont	h, Day, Year)	
		1	30. Name and ddress of person w	ho completed source	of again /line age.	(Tunn !	D3658	9		l l	larch	28, 2	005	
			Dr. John Woods					7, Sa	lisb	ury. M	218	04		
:	Sta		31. Date filed (Month, Day, Year)	32. Reg	rar's Signature									
	Registr	ar	MAR 3	0 2005	coeve L	7 1	Boll							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMIC THE LAKE SALISBURY 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral Social Security Number 8. Date of Birth (Month, Day, Year) 1 □ M 2 2 F Months Days Hours Min 230-52-548 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event, the Medical Examiner must be notified at Yes 2 □ No Be Completed by Funeral Director Conico 10f. Zip Code 1,0g. Citizen of What Country? 2180 or Items 23a AT HAYbor PT DR. ted 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes, Give 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3€Widowed 4 □ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: If Item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) W. 1reherNe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryoe MIGNON H. ANDERSON Dungater other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. L. carlon - City or Town, State *Burial 2 Cremation 3 Removal from State Department o Importent: If any injury or once. ö ' 4 ☐ Donation 5 ☐ Other (Specify) 1-05 22. Name and Address of Facility Wild Maden FUNERU 21. Signature of Funeral Service Licensee Rd ACCOMAC MARTIN 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 40NIA VEUZ Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ours after death. neral Director: After this certificate has been signs filled in by the funeral director, page 2 should be 12 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA Inpatient 27. Manner of Death 1. Natural ate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral L Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1714256 127101 4aace Leep

Registrar

DHMH 17 Rev 1/2001

State

gistrar's Signature

40571CE SA113150R

hd address of person who completed cause of death (Item 23a) (Type, Print)

3

1 2005

			For State Registrar	State of Marylar		artment of F				ene 0 0 5	12611
	Physici		1. Decedent's Name (First, Middle, Last)	M	<u> 200</u>	wan		2. Da	te of Death onth	Day Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stre	e at the l	ake	4b. City, Town, o	listo	of Death		4c. County of D	comice
	Funeral Director		5. Social Security Number 219-64-1786 Usual Residence of Decedent	2□ F 7. Age (In yrs.	Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (M	te of Birth onth, Day, Y . 21,	(ear)	Birthplace (State or Foreign Country) Y
	Aaryland f show	ō	10a. State 10b. County		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 X No
	r 28a-	rect	MD QUEEN ANN 10e. Street and Number	E S QUE	EENSTOW	10f. Zip Code			100	g. Citizen of What	Country?
	th witi	aiD	6736 MAIN STREET			21658			U	SA	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23e or 28a-f show any injury or other traumatic event, the Medical Exactinal must be notified at once.	d by Funeral Director	11. Marital Status 12. 1 X Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2▼ No	lispanic Or an, Mexica Specity:		es or No- etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc.
21215-0036	within 72 h ene. than "natu he Medical	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 12	ion ompleted) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retired NTTED	during mos	st of working		Sb. Kind of Busine CARPENTR	
	filled I Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)		CARLE	IAT TAK	18. Moth	er's Name (First			.1
Maryland	hould be d Mental marked matic ev	ToB	RICHARD MCGOWAN 19a. Informant's Name/Relationship (Type,	Print)	19h Mailin	g Address (Street		NNE DYER		Situat Tour State	- Zin Code l
Z	lith an 27 is r		JAMES H. KNIGHT/FRI	•		MAIN STE				•	_ '
Baltimore,	ages 1 au ent of Hea nt: If item y or othe	1000	20a. Method of Disposition 1 □ Burial 2 【Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	20b. I	Place of Dispo cemetery, cren ESAPEAK	sition (Name of natory or other place E CREMAT	ce)	Date 04/01/20	20	STEVENSV	or Town, State
Baltir	permit. F Departme Importar any injur	Ì	21. Signature of unerary rvice License	(S)	. FE	Name and Addre	ss of Facili	IBETN &	NEWNAN	TIMERAI	HOME, P.A.
8760,	Physician /Medical Examiner supplies the private su	al Examiner	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of limited and the consecution resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter unuerlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection) Due to (or as a consection) Due to (or as a consection)	quence of):	er the mode of dyin		cardiac or respi		t,	Approximate Interval Between Onset and Death (MON) INS
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Division of	iding Physis Ih, After this funeral di	-		28a. ate of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	y at	28d. De		ce 6 □ Other (S _i injury occurred	Decity)
Divisi	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Sweide 6 Could not be	28e. Place of Injury - At h building, etc. <i>(Specil</i>	ome, farm, stre			28f. Lo	cation (Streety or Town, S		Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Direc completely filled in by	edical C	29a. Certifier Check only 2 Medical Examiner	an: To the best of my kno On the basis of examina and manner stated.	owledge, death	occurred at the tin restigation, in my o	ne, date an pinion, dea	nd place, and duath occurred at the	e to the caus ne time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)
	To the within To the comp	Me	296. Signature and title of certifier	IN	כיו	29c. License	a number	278	29d	. Date signed (Mo	nth, Day, Year)
	ki/ e/		30. Name and address of person who comp	A - 1 /	17	2	Ray	1222	2	126	-05 UD 21802
	Sta Registra		31. Date filed (Month, Day, Year) MAR 3 1	32. Register's Signa 2005	ature &	Sperke	YVX	1/00	EU,	, A	V 10 0 7

		_	For State Registrar	State of Marylar	•	artment of I			Reg. No. 2005	12612
П	Physici		Decedent's Name (First, Middle, La					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		David 4a. Facility Name (If not institution, gi	R. ve street and number)	11	finton 4b. City, Town, o	or Location of Death	March 2	6 2005 4c. County of Deal	11:10p
	LXdillic	e.	Fairland Nursin	g Home		Silver	Spring		Montgome	erv
	Funeral Director			Sex 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Day		thplace (State or Foreign ountry) T Virginia
100	Now I		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
3	a-fst	ctor	Maryland Montgo	mery Sil	lver Sp	ring				1 ☐ Yes 2 ☐ No
1	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
1	18 23e	eral	10120 New Hampsh	ire Avenue #205 12. Was Decedent Ever in U			903	pacifu Vas or Na	USA 14. Race - Ame	anican Indian
- 1	item ingr	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	.5.	If Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puert	o Rican, etc.)	Black, Whit	
20	el', or		3 ☐ Widowed 4 ♣ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1□Yes 2☐No	Specify:		Specify: Whi	lte
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Maryland	ked c	To Be	Russell M. Minton	n				E. Jam		
a	snous and M s mar umet		19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street			or, City or Town, State, 2	Zip Code)
Σ	and 2 palth a n 27 is		Fred A. Minton /				Woods Dr	ive Sara	sota, Flori	da 34239
ore:	or of H		20a. Method of Disposition 123 Burial 2 Cremation 3	,		sition (Name of matory or other pla	ice)	Date	20c. Location - City or	Town, State
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Baitimore,	Department of h Importent: If ite eny injury or of		21. Signature of Funeral Service Lice	Lu ou					ldi Funeral ilver Sprin	Home ng, MD 20904
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_ '	age	Con							med? death? 2 X No 1 ☐ Yes	
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0 4	After this funeral dir	tion: To	1 Yes 2 XXIII 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju			ence 6 Other (Specow injury occurred	cify)
DIVISION	fter dea Jirector in by the	Certification:	3 Suicide 6 Could not 4 Homicide determined	be 280 Blace of laiun; At h	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow	itreet and Number or Ru n, State)	ural Route Number,
	within 24 hours a To the Funerel C completely filled	edical (29a. Certifying P (Check only one) Check only one)	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the d rred at the time, d	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To 11	M	29b. Signature and title of certifier	n n	1	29c. Licens	se number		29d. Date signed (Monti	h, Day, Year)
	1 0		Ilan o	Klara	Vil	D52	261		March 27,	2005
1	2		30. Name and address of person who	/			m Comi-	V1	-4 2007/	
C	- Y		Alan R. Segal, I				r Spring,	, магута	14 200/4	
4	Sta Registi		MAR 3 0	32. Projectrar's Signation	B. A	care				

			1 For State			nd / Depa		of Health	and M	lental Hyg	211115	12613
			Registrar 1. Decedent's Name (First, Middle, Las	r)			imouto	0, 000.		2. Date of Dea	Reg. No:	3. Time of Death
П	Physici		Kathleen E. Mille							Month March	Day Year 27, 2005	
	/Medic Examir		4a. Facility Name (If not institution, give	street and num	nber)		4b. City, To	wn, or Location	on of Death	naich	4c. County of De	3.03
Н	LXamii		Montgomery Hospi				D.	ockvil	1.0		Montgon	
	Funeral		5. Social Security Number 6. Se	×		. last birthday)	If Under 1	ear If Und	ler 24 Hrs.	8. Date of Birtl (Month, Day	Montgon 9. Bi	rthplace (State or Foreign country)
	Director		217-10-7203	_M 21€7F	86	Yrs.	Months [ays Hour	s Min.		1, 1919	Ohio
	р ,		Usual Residence of Decedent		100 0	it. Town and						
	anyla shov	-	10a. State 10b. County Maryland Montg	omeru	106. 0	ity, Town or Lo	lver S	orina				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	M er R	Director		Omery		21						V
	vith ti	i	10e. Street and Number				10f. Zip C				10g. Citizen of What C	ountry?
	s 23c	Funeral	15300 Beaverbro					2090			USA	
	er de Itam Der D	un.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dece	ces?	J.S. 13.	Was Deceder If Yes, specify	t of Hispanic Cuban, Mexi	Origin? (Spe can, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs aff	by F	3 X Widowed 4 Divorced	1 ∐Yes If Yes, Giv Year or Da	9		1 ☐ Yes 2 ☐	No Spec	ify:		Specify: V	Mite
ŏ	within 72 hours after death with the Maryland ene. than "natural", or Itams 23s or 28s-f show the Medical Esaminer must be notified at		15. Decedent's Edi	ucation		16a. Dece	dent's Usual (ccupation			16b. Kind of Business	s/Industry
715	n n	Completed	(Specify only highest grad Elementary/Secondary (0-12)		4055.)	(Give	kind of work DO NOT use	done durina m	ost of worki	ng		
2	d with	E	12	College (1	401 5+)	Но	nemake				Own Ho	me
b	e file al Hyg othe vant,	Bec	17. Father's Name (First, Middle, Last)					18. Mo	ther's Name	(First, Middle,	Maiden Sumame)	
<u>a</u>	uld build by Aentz	ToE	Victor May						Edna	Rexroad		
Maryland 21215-0036	and Nema		19a. Informant's Name/Relationship (T	ype, Print)		19b. Maili	ng Address (S	treet and Nun	nber or Rura	l Route Numbe	r, City or Town, State,	Zip Code)
	and 2 valth valth ser tre		Donald V. Miller/	Son		167	ll Goos	seneck	Terra	ce, Oln	ey, Maryla	nd 20832
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic avent. The Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	7	20b.	Place of Dispo	sition (Name natory or othe	of r place)	March	ate 31.	20c. Location - City o	r Town, State
Ĕ	Pag nent ant: I		'4 □Donation 5 □ Other (Specify,)	Ga.	cemetery, crei te of He	aven Cen	etery	200	- 83	Silver Spr	ing, Maryland
alti	permit. Departrimports Imports any inju		21. Signature of Funeral Service Licens	600	·	22	Name and	ddress of Ea	i ins		1 Home Inc	
m	89 = 29		dames 31	Jack			500 Un	versit	y Blv	d, W, S	ilver Spri	ng, MD 20901
760,	Physician / Medical Examiner	cal Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	ple My or as a conse or as a conse or as a conse	quence of):						Interval Between Onset and Death Months
P.O. Box 687	the death certifica by the attending phached for use as th	Physician/Medic	in the past 12 months? 1 Yes 2 XNo 9 Unknown	4∏Pregna 9∏Unkno	rth 2 □ Fet unt at time of wn	al death 3 death 5	Ectopic preg	(y)		07. 514	23d. Date of de Month	Day Year
	w requires that been signed to should be det	by	Part II. Dther significant conditions co	ntributing to de	atii Dut not re	sulling in the u	nderlying caus	e given in Pa	π. ι.		bacco use contribute t	robably 4 Unknown
0	requ	etec										
il Records,		Completed								24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of
Viital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:					ice of Death	(Check only or	10)	
Division of	ding Phys	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date o		28b. Time of Injury		Other: 4 Injury at Work? 1 Yes 2	2		ence 6 N ther (Spectred)	racify) Hospice Facility
Divis	= 00 >	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildin	of Injury - At h g, etc. (Speci	nome, farm, str	eet, factory, o	fice	2	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)	sician: To the ner: On the ba and mann	sis of examin	owledge, death ation and/or in	occurred at the control of the contr	he time, date my opinion, d	and place, a eath occurre	and due to the co	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the To the To the Comp	ž	29b. Signature and title of certifier				29c. L	cense numbe	ľ	2	9d. Date signed (Mon	th, Day, Year)
	5		Christ aga	4000				D4245	2		March 28	, 2005
	7		30. Name and address of person who o	mpleted cause	of death (Ite	m 23a) (Type,	Print)					
			Chitra Rajagopal	M.D.	18111	Prince	Phili	p Driv	e, #3	27, Olne	ey, MD 208	32
į	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 200	5 3. Re			444					

			4 101	partment of Health and Me ertificate of Death	2000 12614
			Decedent's Name (First, Middle, Last)		Reg. No. Date of Death 3. Time of Death
	Physici		Eileen Jane Murray		Month Day Year
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1	Exami	lei	6909 24th Avenue		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Lewisdale y) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year) Prince George's 9. Birthplace (State or Foreign Country)
	Director		578-24-2022 1□M 2⊠F 80 Yrs.	Months Days Hours Min.	(Month, Day, Year) Country) 15.11,1925 Washington, D.C.
	D .		Usual Residence of Decedent		washington, b.C.
	inylar show	_	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	Ba-f s	cto	Maryland Prince George's Lewi	sdale	1 ☐ Yes 2 ☑ No
	ih th or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	within 72 hours after death with the Maryland ane. then 'neturel', or iteme 23a or 28a-f show 'as Nedleul Evairti at mast be motified at		6909 24th Avenue	20783	USA
	Iteme	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc.
36	or I	by Ft	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No Specify:	Specify:
Ö	urel'	d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		White
21215-0036	be filed within 72 hours after de ital Hygiene. Ind other then "neturel", or lleme event, Ita Mudicul Eraininar n	Completed	(Specify only highest grade completed) (Gin	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
12	withi	mc	Elementary/Secondary (0-12) College (1-4or 5+)	· ·	
	filed Hygir ther		17. Father's Name (First, Middle, Last)	nistrative Assistant	University First, Middle, Maiden Surname)
an	ould be Mental arked o	To Be			
Maryland	ages 1 and 2 should be nt of Health and Menta t: If item 27 is marked / or other treumatic ev	F	Harry Frederick Krup 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Helena Cla	ir Paquin Poute Number, City or Town, State, Zip Code)
S	and 2 ealth a n 27 is		Lanca de la companya	800 to to the terminal	2,1200
ē,	Hea Hea tem		20a Method of Disposition 20b Place of Dis	nosition (Name of Date	ale, Maryland 20783 20c. Location - City or Town, State
2 D	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	ematory or other place) itan	0005
Baltimore,			,	rematory Mar. 28	2005 Alexandria, Virginia
Ba	permit. Departr Importe any inje		School Ladi	22. Name and Address of Facility rancis J. Collins Fu	neral Home, Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not e		W., Silver Spring, MD 20901 aspiratory arrest, Approximate
	SE WIL		shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	(arcinomatos	Smonths
	Examiner		Due to (or as a consequence of):		
		iner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	uted d ansit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
Ć.	exec n an ial-tra	Exami	resulting in death) Last Due to (or as a consequence of):		
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dical	d		
9	tificat g phy as th				
Вох	eath certific attending p	ian/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
	deatl	icia	1 Ves 2 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
P.0	by the tached	Physici	9 □ Unknown		
	requires that een signed b nould be deta	ру Р	Part II, Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Records,	w require been sig should b				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown
SCO	faw requast been 2 should	ompieted			24a. Was an 24b. Were autopsy findings available
	The te h age	E			autopsy performed? performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
Vital	sicien: certifica rector, p	e C	25. Was case referred to medical	26. Place of Death (C	A
>	ys di	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Other	5 ☑ Residence 6 □Other (Specify)
J of			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		. Describe how injury occurred
Ö	Attending r death. ector: After y the fune	atic	2 Accident investigation	M 1 Yes 2 No	
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
	telor rs afte al Dir	Cer			
	e Hospitel of 24 hours at B Funeral D etely filled i	cai	29a. Certifier (Check only (C	th occurred at the time, date and place, and	due to the cause(s) and manner as stated.
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	fedic	one) and manner stated.		
	Mith To 1	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•			- Juny y May PM	D 43260	March 28, 2005
	12		30. Name and address of person who completed cause of death (Item 23a) (Type		
			Jenny Y. Moy, M.D. 13952 Baltimor	e Avenue Laurel,MD	20707
	Sta Registr		31. Date filed (Month AR 2 9 2005 32. Angistrar's Signature	Goarle	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mar. 15,2005 **Physician** 5:40 am Jean Lindlaw Morris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery Chevy_Chase Manor Care If Under 24 Hrs. Hours Min. 8. Date of Birth
Feb. Day Year) 1923 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral 9. Birthplace (State or Foreign Months Days 142-16-4665 1 □ M 2 🖾 F Bloomfield, NJ 82 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

When than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examples instituted all 1 Tyles 2 □ No MD Director Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20816 5702 Kirkwood Dr. USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3

Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bridal Consultant Catering Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roger Hart Gertrude Callahan ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Lindlaw / Son 5702 Kirkwood Dr. Chevy Chase, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9 Comfort Crematory 03 22/05 | Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawlers Sons, INC M01378 5130 Wisconsin Ave. N.W., Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Else only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Advanced Dementia Examiner Due to (or as a consequence of): Examiner Hypertension ettending physician and for use es the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Anorexia Physician/Medical Due to (or as a consequence of): B 12 Deficiency Anemia Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? the Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ģ ete has been sign page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificete has 1 Yes 2 No 1 Yas 2 10 To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funerel Director: After this certifice ofter death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X□ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-20274 March 16, 2005 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra M.D., 7710 Bradley Blvd., Bethesda, MD 20817 32 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

			For State Registrar	State of Ma	ırylan				lealth a <i>Death</i>	nd Me		giene Reg. No.	2005	12	SIC
	Physici /Medic		Decedent's Name (First, Middle, L ANGELA NICOLE Mo	MICHAEL							2. Date of De Month MARCH	26	2005	3. Time of 1:10	P M
	Examin	er	4a. Facility Name (If not institution, gu. 4720 Phillips Ros. 5. Social Security Number 6.	ıd '	(In vrs	last birthday)	La	Town, o	r Location of ta		B. Date of Bird	C	County of Death		or Foreign
4	Funeral Director			1 ☐ M 2 🛱 F	19	Yrs.	Months		Hours	Min.	(Month, Da	y, Year)	985 Was		DC.
	e Marylan 3a-1 show	ctor	10a. State 10b. County Maryland Charles			y, Town or Lo	ocation	_						10d. Inside Ci	ity Limits 2 MNo
	h with th	Funeral Director	10e. Street and Number 4720 Phillips Ro	oad.			10f. Zi	Code 2	0646			10g. Citi	zen of What Cou USA	intry?	
5-0036	be filed within 72 hours atter death with the Maryland ital Hygiene. Id other than "natural", or liems 23a or 28a-f show event. Its Medical Exam are mun be indiffed at	þ	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Was Dece If Yes, spe 1 Yes		lispanic Orig an, Mexican, Specify:	in? (Spec , Puerto R	ify Yes or No ican, etc.)		14. Race - Ameri Black, White Specify: Whit	, etc.	
21215-0	within 72 ho ane. than "natur the Medical I	Completed	15. Decedent's i (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5-	+)		kind of wi DO NOT L	ork done i ise retired	ation during most t) ving (nd of Business/Ir	ndustry	
Maryland 2	a la b	To Be Co	11. Father's Name (First, Middle, Las Kenneth W. McMich			CILEP	9/ -		18. Mother	r's Name (First, Middle,	Maiden		_	
	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic	7 9	19a. Informant's Name/Relationship Racheal C. DeMarr			4720	Phi1	lips	Road		Route Numbe		Town, State, Zi 0646	p Code)	
Baltimore,	Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition Burial 2 Cremation 3 Other (Special Content)			Place of Dispo cemetery, cres nity Me			-	Da S 3-2			cation - City or T dorf, M		
Balt	permit. Pages Department of Important: If it any injury or o		21. Sign we of Aneral Serve Lice	MOO1	73				ss of Facility	Eber			al Serv		
)	Physician /Medical Examiner		23a Ant. Enter the disease, or conflock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	mplications that caused y one cause on each line. a. Due to (or as a	36	ast	er the mo		_		respiratory a			Approximat Interval Bet Onset and I	ween
3760,		lcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a											
O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 🗌 Feta	ildeath 3□]Ectopic p		,			2	3d. Date of deliv	,	Year
ecords, P.	w requires that is been signed by should be deta	by	Part II. Other significant conditions	contributing to death bu	it not res	ulting in the u	nderlying	cause giv	en in Part I.			obacco u res 2[se contribute to		ieath? Inknown
~		Completed											24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings ompletion of c	
Vital	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner?	Hospital:	nt 2 🗆	ER/Outpatier	nt 3 🗆 D	OA Oth	ar	of Death	Check only o		□Other (Speci	(hu)	
Division of	ing Ph		27. Manner of Death Natural 5 Pending Accident investigati	28a. Date of Injury (Month, Day)	v	28b. Time of Injury		28c. Injun Wor		28	3d. Describe f			.,,	
DIVIS	the Hospital or Attend hin 24 hours after death the Funerel Director: / mpletely filled in by the f	Certification;	3 Suicide 6 Could not determine		ry - At h	ome, farm, str y)	eet, factor	y, office		28	of. Location (5 City or Tow		d Number or Rur	al Route Num	ber,
	To the Hospital within 24 hours a To the Funerel completely filled	Medical	(Check only 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner stat	examina	owledge, death	vestigation	n, in my o	ne, date and pinion, death e number	d place, and h occurred	at the time,	date and	place, and due t	to the cause(s)
(wit To	-	29b. Signature and title of certifier	MI	10	th		0)	L. J.	35	2	3)	signed (Month,	Soy, rear)	
1	B		30. Name and address of person who	32. Re ústra	1	70	Print)	1	s P	Lo	Ja	M	00	061	16
P	Sta Registr		MAR 2 9	2005	CAR.	15	STORY.								

			State of M	aryland / Depa	artment of H		-	_	
			1 - For State Of IV	Cei	rtificate of D	Death	Rag.	No.2005	12617
	Physici	an	1. Decedent's Name (First, Middle, Last)					Day Year	3. Time of Death
	/Medic Examin		Opal Imajean Morehead 4a. Facility Name (If not institution, give street and number		4b. City, Town, or	Location of Death	March	4c. County of Dea	1001
	Examin		Union Hospital		Elkton			Cecil	
	Funeral		5. Social Security Number 6. Sex 7. A 1 M 2 1 F	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) C	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	71 Yrs.			April 6,1	933	wv
	show	ř	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	the M	by Funeral Director	MD Cecil 10e. Street and Number	Rising	Sun 10f. Zip Code		10g.	Citizen of What C	
	th with	al Di	27 LaFayette Ave.		21911		usa		
	terns	uner	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F		14. Race - Am Black, Whi	
920	urs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	No	1 ☐ Yes 2 🛣 No	Specify:		Specify: Wh	ite
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. yther than "neturel", or items 23e or 28e-f show ant, the Medical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of workir	166	. Kind of Business	/Industry
121	within ene. than "	mpi	Elementary/Secondary (0-12) College (1-4or	5+)	DO NOT use retired) Emaker	Ů		Own Home	
d 2	il Hygi other	Se Co	17. Father's Name (First, Middle, Last)	Home		18. Mother's Name	(First, Middle, Mai		
ylar	Menta Menta arked etic ev	To Be	Joseph Daniel Tilley			Hazel B.	lankenshi	.p	
Maryland	d 2 shoth and the and 7 is m		19a. Informant's Name/Relationship (Type, Print) Jeffrey S. Morehead/son		ng Address (Street a			-	Zip Code)
	s 1 and f Heat item 2 other		20a. Method of Disposition	20b. Place of Dispo	Fayette Aversition (Name of matory or other place	D:	ate 20c	1D 21911 Location - City of	Town, State
<u>ii</u>	Page nent o ent: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)		Baptist Co	07/02	/2005 R	lising Su	n, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel; or items 23e or 28a-f show morphy ijury or other treumetic event, the Medical Enablish must be notified at once.		21. Signature of Funeral Service Licensee	die 22	2. Name and Address	s of Facility R.T Zen Stree	. Foard F t, Rising	uneral H Sun, MD	ome, P.A. 21911
			23a. Parth. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each						Approximate Interval Between Onset and Death
}_	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	2 Myoca	urdial I	or fer cti	'on		2 hours
	Examiner		1501	a consequence of):					vears
	φ ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					72.27
4	xecute and al-trans	Examiner	that initiated events C.	a consequence of):					
68760,	te be executed ysician and te burial-transit	calE	d						
89	ing ph)		IF FEMALE:						
Вох	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	by Physician/Med	23h Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
P.O.	t the di	hysic	1 ☐ Yes 21 No 9 ☐ Unknown	tune or death 5	Other (specify)	-			
S, F	es tha igned l	by P	Part II. Other significant conditions contributing to death			n in Part I.		12	the cause of death?
ord	requir	eted	Insulin Deppn Jens	1/12/01-	~)		1 Tes		robably 4 Unknown
Rec	he law e has l	Completed					24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	ian: T	BeCc	25. Was case referred to medical			26. Place of Death	1 ☐ Yes 2.2 (Check only one)	No 1 ☐ Yes	: 2□ No
of <	Phyeic this ce al dire	2	examiner? 1 Yes 2 No Hospital: 1 Inpati		t 3 DOA Other	4 Nursing Hom			cify)
OU	th. : After funer	tion	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident investigation	y Year) 28b. Time of Injury	Work?	at ? es 2 □ No	8d. Describe how i	njury occurred	
Visi	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, stre	eet, factory, office	2	Bf. Location (Street City or Town, St		ural Route Number,
	urs aft eral Di							<u> </u>	4
	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner s	of examination and/or inv	n occurred at the time vestigation, in my opi	e, date and place, a inion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and du	s stated. e to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier		29c. License	_		Date signed (Moni	
)			Mr. farkes, M	D	D15	314	MI	erch 29	2005
	7		30. Name an address if person who completed cause of	death (Item 23a) (Type,	Print) E/K	Ton 1	1 D		
	Sta	te	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	, 01/	, , , , , , , , , , , , , , , , , , , ,	· V		
	Registr	ar	MAR 3 0 2005	M. Ansa	82				

DHMH 17 Rev 1/2001

			for State	te of Ma	ryland		rtment of H				g ⁽⁷⁷⁾ , p+10, kg	
			1 - State RegistrarAmended # 4 per 1. Decedent's Name (First, Middle, Last)	FH; F	CHD	Cer	tificate of	Death 4/4	/ 2005TM 2. Date of De			12618
	Physici	an	1. Decedent's Name (First, Middle, Last)	11					Month /	Day	Year	6:15. PM
1	/Media	al	Mober Lee 1	noye	rs		41 O't T	-1	March		2005	6.13.PM
4	Examir	er	4a. Facility Name (If not institution, give street at	nd number)			•	r Location of Deatl	n		nty of Death	
			10 S. Maple Avenue	7 450	(In two In a	a friedrata)	Brunsw:	LCK If Under 24 Hrs.	O Data of Ria		derick	
	Funeral		5. Sporjan Security Myrighton 6. Sex	_	(In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da June 7	y, Year)	Coun	lace (State or Foreign
	Director		Usual Residence of Decedent						Julie /	1930	патт	Lisonburg VA
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation				11	0d. Inside City Limits
	Mary High	ō	MD Frederick		Brur	ıswick	:				1	1⊠Yes 2□No
	1 the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen a	of What Coun	itry?
	3a o		10 S. Maple Avenue				2171	6		U	SA	
	ms 2	Funerai	11. Marital Status 12. Was	Decedent Ev	ver in U.S.	13. V	Vas Decedent of H	lispanic Origin? (S	pecify Yes or No	- 14. R	lace - America	
(0	r ite	교	1 Never Married 2 Married 1	ed Forces? Yes 2⊠No	0	"	Yes, specify Cuba	an, Mexican, Puert	to Rican, etc.)	В	lack, White,	
93	ali, o	þ	3 ☐ Widowed 4 🔁 Divorced Yea	es, Give r or Dates:		1	☐ Yes 2⊠ No	Specify:		Spec	city: Whi	.te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or tems 23a or 28a-1 show the Modical Examidrational be multified at	Completed	15. Decedent's Education (Specify only highest grade complete	eterl)		16a. Deced	ent's Usual Occup	ation	rkina	16b. Kind of	Business/Ind	dustry
2	within ene. than "	npie		ege (1-4or 5+	-)	life. L	OO NOT use retired	d) -	Anty	N.I.		
2	filed wi Hygien sther th	Con	8				Custodian				esda,	MD
pu	2 should be filed within 72 hc and Mental Hygiene. Is marked other than "natu aumatic event, Itte Modical	Be	17. Father's Name (First, Middle, Last)						ne (First, Middle,		ame)	
Va	should be and Mental I is marked o	T _o	Virgil Moyers, Sr.					France	s Willia	ams		
Maryland	and and is m		19a. Informant's Name/Relationship (Type, Prin	•			g Address (Street			-		Code)
	473 d		Betty Lou Brooks, Sis	ter			Central A	venue, B				
ore	of Ho		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal	from State	сел	netery, cřen	sition (Name of natory or other plac		Date	20c. Location	n - City or To	wn, State
<u>Ē</u>	Pages ment of ant: if its ury or o		' 4 ☐ Donation 5 ☐ Other (Specify)	4	Hage	erstow	n Cremat	ory 3/29	/2005	Hagers	town,	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or othar once.		21. Sign to 1 uneral Service Lioused Barbara A. William	s, Own	er	J C	Name and Addre hn T. Wi O Peters	ss of Facility 1111ams F	uneral H	lome	MD 21	716
	- 2		23a. Part1. Enter the disease, or complications								TID Z1	Approximate
	C I		shock, or heart failure. List only one caus Immediate Cause (Final	A 9 2		,		1.	/	2		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ue to (or as a			ic Car	aiovas	cular	- U150	ase	20 minute
	Examiner			40 to (01 43 4	Conseque	1100 017.						
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a	conseque	nce of):		•				
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ć	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Еха	and a state of the	ue to (or as a	conseque	nce of):						
8760,	ate be physicia the but	dicai	d									
9	iificat ig phy as th	edi										
Вох	leath certific attending p	Physician/Me		s, outcome of			Ectopic pregnancy			23d. 0	Date of delive	ry
	deatle e atte	icia	1 Ves 2 No	Pregnant at ti			Other (specify)		·	N	Vio nth	Day Year
P.0	by the destached	hys	9 □ Unknown	Unknown								
	res tha igned l be det	by P	Part II. Other significant conditions contributing	g to death but	t not resulti	ing in the ur	iderlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute to th	e cause of death?
Records,	w require been sig should b	ed								Yes 2□No	3 ☐ Proba	ably 4 □Unknown
Š	law re as be 2 sho	Completed							24a. Was		. Were autor	osy findings available
ď	The laste has page ?	E O								rmed?	death?	npletion of cause of
Vital		0	25. Was case referred to medical					26. Place of Dea	ath (Check only o			
\	di is	ToB	exammer? 1 Yes 2 No Hospital:	1 🗌 Inpatien	t 2 🗆 EF	VOutpatien	3 □ DOA Oth	er: 4 Nursing H	lome 5 Resid	dence 6 🗆 O	ther (Specify)
J Of			27 Manner of Death 28a. 1 XNatural 5 ☐ Pending	Date of Injury (Month, Day	Year) 2	8b. Time of Injury	28c. Injur	y at k?	28d. Teso be l	now injury occi	urred	
Ö	uttendir death. ctor: Al y the fu	atlc	Accident investigation				M 1	Yes 2 □ No				
Division	if or Attending after death. Director: After In by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injur- building, etc.	y - At hom (Specify)	e, farm, stre	eet, factory, office		28f. Location (3 City or Tox	Street and Nun vn, State)	nber or Rural	l Route Number,
	itai o rs aft al Di	Cer										5
	To the Hospital within 24 hours at To the Funeral Completely filled it	cal	29a. Certifier 1 Certifying Physician: Medical Examiner: On	To the best of the basis of e	my knowle	edge, death n and/or inv	occurred at the tin	ne, date and place	, and due to the	cause(s) and r	manner as sta	ated. the cause(s)
	the land 2. The factor of the	Medical	one) / and	manner state	ed.							
	5 ± 5 00	==	29b. Signature and title of certifier	1	1.		29c. Licens	o municer	_	29d. Date sign	ied (Month, L	Jay, rear)
,	24		Ileu Ko	lives	14	1)	100	3/17	7	_3	-29	-2005
	17		30. Name and address of person who complete	d cause of dea	ath (Item 2	3a) (Type, i	Print) th_ <	C. I	1 /	NAM	> 11	201
			Han Sohrer	(4-)	15	W	1	rec	derick	IND	616	01
	Sta		31. Date filed (Month PARes) 1 2005	32. Registrar	r's Signatui	e de la	lange At			Į.		
	Registr	ar		1	-water et	Salar Salar	and the same					

		1	For State	State of M	aryland		artment of F		nd Mental I		64	0.5	1261	0
			Ragistrar 1. Decedent's Name (First, Middle,	Last)		Cer	uncale of	Dealli	2. Date of	Reg. N	0.		3. Time of Death	n J
	ysicia	ın	Jessé	,	nald,	Ir			Month March	0	ay Q 1	Year 2005	12:50 A	M
	ledic amin		4a. Facility Name (If not institution,			51.	4b. City, Town, o	r Location of				of Death	12.JU A	
_A			Citizen's Nurs	sing Home			Fre	edericl	k		F	reder	ick	
Fund	eral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. las	• •	If Under 1 Year Months Days	If Under 24	Min. (Month	Birth , Day, Yea	r)	9. Birthp Cour	lace (State or Fore	aign
Direc	ctor		216-22-7817	TIZEM 2CIF	78	Yrs.			Sept.	3, 1	926	Mary	land	
land	10	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Lim	nits
Mary -1 sh	led.	ţo	Maryland Freder	rick	Fred	dericl	2						1 ▼Yes 2 □	No
h the	125	irec	10e. Street and Number		11100	uci ici	10f. Zip Code			10g. C	itizen of	What Cour	ntry?	
th with	1	Funerai Director	1109 Rocky Spri	ngs Road				2170)2	τ	Jnite	d Sta	ates	
r dea	E J	ıner	11. Marital Status	12. Was Decedent Armed Forces		13. \	Vas Decedent of H	lispanic Origi an, Mexican,	in? (Specify Yes of Puerto Rican, etc.	r No-		ce - Americ ck, White,		
s afte	al Land	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		☐ Yes 2☑ No	Specify:			Specif		ite	
lural bour	E	edb	15. Decedent'	Year or Dates:	1	16a Decer	lent's Usual Occur	ation		16h	Kind of F	usiness/In	dustry	
n 72	Medic	Completed	(Specify only highest	t grade completed)		(Give	kind of work done OO NOT use retire	durina most d	of working	100.	Trans or D	431110334111	24307	
d with	The state of	mo	0	College (1-4or	5+)	P1ur	nber			Cit	y Go	vernn	nent	
idilia Z I Z I 3-0030 d be filed within 72 hours after death with the Maryland ental Hygiene. The other than "netural", or fleme 23a or 28a-f show	vent,	BeC	17. Father's Name (First, Middle, L	ast)				18. Mother	's Name (First, Mic	ddle, Maide	n Sumar	ne)		
should be	atic	2	Jess Thomas					Mau	ıde Smith	l				
2 sho	Laru Laru		19a. Informant's Name/Relationsh						or Rural Route Nu	•				
1 and Health em 27	thert	-	Kathleen V. McI 20a. Method of Disposition	onald/ Wife			Rocky Spr sition (Name of	_	Road Fre			aryla City or To		-
Pages nent of h	0 0		1 X Burial 2 ☐ Cremation		cen	netery, cren	natory or other pla	e) A	April 1, 2005					
DELLITIOTE, MICT YIGHTO ZIZIO-0050 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show	injury F	ŀ	* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		Mt.	OLIVE	t Cemete	ss of Facility	2005	Fre	deri	.ck, N	Maryland	
permit. Departr Importe	any ir		1X) Q Q J=	4		110	zi oposs	umtown	Stauffer Pike F	reuer	ral ick,	Mary	1and 2170)2
			23a. Part1. Enter the dise ase, or o shock, or heart latters. List of	complications that cause only one cause on each I	d the death. ine.	Do not ente	er the mode of dyin	ng, such as ca	ardiac or respirato	ry arrest,			Approximate Interval Between Onset and Death	
Physic	_		Immediate Cause (Final disease or condition resulting in death)	_a_ tne	eum On	14							Days	
/Medi Exami	_		Tooling in doday	Due to (or as	a conseque	F .							months	
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as									Mercina	
de d	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											N
o, s exec	rial-tr	Exa	resulting in death) Last	Due to (or as	a conseque	nce of):								
The law requires that the death certificate be executed ate has been signed by the attending physicien and	the bu	licai	1	d										
uries that the death certifice signed by the attending ph	9 85	Physician/Med	ff FEMALE:	20- 16	-4									
ath cer	for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)	/				ite of delive onth	Day Year	
the de	ched	ysic	1 □ Yes 2 No 9 □ Unknown	9□ Unknown	it time of dea	3	Cities (specify) _							_ "
that	deta	by P	Part II. Other significant condition	ns contributing to death t	out not result	ing in the ur	nderlying cause giv	en in Part I.	23e. D	oid tobacco	use con	tribute to th	ne cause of death?	
w requires	nid be	ieted b							1	☐ Yes	2 No	3 🗌 Prob	ably 4 Unknow	wn
aw ra	2 sho	piet								Vas an utopsy	24b.	Were auto	psy findings availal npletion of cause of	ble
sician: The law	page	Comple								erformed?		death?	2 No	"
VILLAI ician:	ctor.		25. Was case referred to medical examiner?						of Death (Check or					
ding Physician; The I h. After this certificate ha	al dire	2	1 ☐ Yes 2 No		ent 2 El		-	Nurs	sing Home 5 F				/)	
nding I	funer	ion	27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investig		ay Year)	8b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2.⊟N	28d. Descr	ibe now inj	ury occur	red		
Atten deat ctor:	y the	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of In	jury - At hom	e, farm, str	eet, factory, office		28f. Location			oer or Rura	l Route Number,	-
after I Dire	d in b	Certification;	4 Homicide determin	building, e	tc. (Specify)		•		City or	Town, Sta	te)			J
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte	completely filled in by the	edical (29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the best examiner: On the basis of and manner st	of examinatio	edge, death n and/or inv	occurred at the tir restigation, in my o	ne, date and pinion, death	place, and due to occurred at the tir	the cause(ne, date a	s) and ma nd place,	anner as si and due to	ated. the cause(s)	
To th To th	dwoo	Me	29b. Signature and title of certified				29c. Licens						Day, Year)	
1)	3			DY	3091		3	-29,	05		
~			30. Name and address of person v	CAIDI	un		Rrint) To	Bu b	touse 1	fre,	R	elive	le, MD	
Re	Sta gistr		31. Date filed (Month ARY eg)	1 2005 32. Post	rar's Signatu	D. A								

			For State					partment of h					200	5	126	20
			- State Registrar Amend 1. Decedent's Name (First	ed #2 , Middle, L	23partII ^{ast)}	per l	m; FCHD	runcate of	Deali	04/0	4/05TM 2. Date of De	Reg. No.			3. Time of	Death
	Physici /Medic		Donald		Ε.		Mo	orrison			March 3		2005 ^Y	ear	3:50	
	Examin	er	4a. Facility Name (If not in			um <i>ber)</i>		4b. City, Town, o		of Death		4c.	County of I			
			Northampton					Freder:		04 1150	T =		rede			
	Funeral Director		5. Social Security Number 216–34–5509		Sex 1.2 X M 2.□F	7. Age (in)	yrs. last birthday 68 Yrs.	Months Days	Hours	Min.	8. Date of Bird (Month, Da July 1	y, Year)			ice (State of ry) yland	Foreign
70	2 *		Usual Residence of Dece 10a. State 10b.	dent		100	. City, Town or I	ocation				,				
Asive	fsho	ō	Maryland	,	lerick	100.	. City, Town of t		rede	rick				10	d. Inside Cit1 Yes	
the	r 28e	Director	10e. Street and Number					10f. Zip Code				10g. Citiz	zen of Wha	ıt Countr	y?	
th wit	23e c	al D	9217 Hambu	rg Rd	l .			217	703			Un	ited	Sta	tes	
ar des	tems	Funeral	11. Marital Status		Armed F		n U.S. 13 L 954–	. Was Decedent of I If Yes, specify Cub	Hispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race Black, \	America White, e		
d 21215-0036 filed within 72 hours after death with the Marvland	ponent. Tages Trains about our most main retained again and seat must be wayful popular. Tages Trains and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show eny injury or other treumetic event, it a Medical Examiner must be notified at once.	by F	1 Never Married 2 3 Widowed 4 D		if Yes, G Year or t	ive 10	962	1 ☐ Yes XX No	Specify:	:			Specify:	Whi	te	
2-0-2	nature lical E	eted		ecedent's E	ducation and completed	1	16a. Dec	edent's Usual Occur e kind of work done	pation	et of work	ing	16b. Kin	nd of Busin	ess/Indu	ustry	
1 ig	hen .	Completed by	Elementary/Secondary			(1-4or 5+)	life.	DO NOT use retire	d)	31 OI #OIA	nng	St	eel]	[ndu	strv	
Q 5	Hygie other t	e Co	12 17. Father's Name (First,	Middle, Las	t)				_	er's Nam	e (First, Middle,					
Maryland 21215-0036	Aental Aental rked c	To B	Horace Mor	rison							Berger		,			
ary	and h		19a. Informant's Name/Re					ling Address (Street							,	
2 °	ealth m 27 her tr		Jennie Jone		ughter	200		Cedar Ridg	ge Rd.							
Baltimore,	nt of F		20a. Method of Disposition 1 Deurial 2 Cere	nation 3 [State	cemetery, ch	osition (Name of ematory or other pla	· 1		Date		cation - Cit			
iti B	artme ortani injury	7	'4 □ Donation 5 □ C			F		ck Cremato 22. Name and Addre							arylaı	nd
m E	impo impo eny ir		Y ourth	ech (Stark	Por		.621 Oposs							1702	
			23a. Part 1. Enter the dise shock, or heart failu	a e or cor e. List only	nplications that y one cause on	caused the deach line.	leath. Do not er	nter the mode of dyin	ng, such as	cardiac	or respiratory ar	rrest,		- 1	Approximate nterval Betw	reen
	nysician														Onset and D	eath
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		Jer	Sequentially list condition if any, leading to immedia	s, te	b. Due to	(or as a con	sequence of):		_					+		
cuted	nd ransit	Examiner	Cause (Disease or injury that initiated events	1	C.											
8760,	physician and the burial-transit		resulting in death) Last		Due to	(or as a con	sequence of):									
687 ificate	physics the t	dical			d					_					-	
I Records, P.O. Box 68760, The law requires that the death certificate be executed	attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, ou							2:	3d. Date of	delivery	,	
. D	he atte	sicia	in the past 12 month 1 ☐ Yes 2 ☐ No			birth 2 TF nant at time		□Ectopic pregnancy □ Other (specify) _	/				Month		ay Y	9ar
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ds,	signed d be del	d by	Lung Canc		contributing to t	Jean Dut not	resulting in the	undenying cause giv	en in Part i	Ι,		res 2		.e to trie	1.	
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		BeC	25. Was case referred to examiner?	nedical					26. Place	of Deat	(Check only o					
	this o	2	1 Yes 2 100	uh -	Hospital: 1 28a. Date		ER/Outpatie		4 LATHU		me 5 Resid			Specify)		
vision of Vita	th. After th funeral	tlon	L./	Pending investigation	(Mor	nth, Day Year	28b. Time Injury	Wor	yat k? Yes 2 □		28d. Describe h	now injury	occurred			
Division of	ector: A by the fu	ertification:		Could not l	28e. Plac	e of Injury - A	t home, farm, s	reet, factory, office			28f. Location (S City or Tow	Street and	Number o	r Rural I	Poute Numb	er,
	el Dire	OL														
Div	within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 C	ertifying P edical Exa	imprer: On the t	basis of exam	knowledge, dea iination and/or i	th occurred at the tirnvestigation, in my o	ne, d <i>a</i> te an pinion, dea	nd place, ath occurr	and due to the deed at the time, d	cause(s) a date and p	and manne place, and	r as stat	ed. he cause(s)	
o the	ithin on the omple	Med	29b. Signature and title of	certifier	and mar	nner stated.		29c. Licens	e number			29d. Date	signed (M	ionth, Da	ay, Year)	
)	S = 0)	nan	1_ ~	re)	000	D	583	91		3-	131	-0	5	
	19		30. Name and address of	person with	completed cau	se of death (Item 23a) (Type	Print) DD					n		1)
			31. Date filed (Month) DA	DYami -	7212,1	Registrar's Si	801	Tall He	nse	H	ve, t	re	clei	rel	1217	701
:^	Sta Registr		St. Date filed (Month,	K 3 1	2005 32.	a strain s Si	griature A	mile							-17	-,

				State of Maryland / Depa		•	
				State Co.	rtificate of Death		70 0 0 m
				Registrar 1. Decedent's Name (First, Middle, Last)	incate of Death	2. Date of Death	3. Time of Death
		Physici	an	Paul Perry Manus Jr.		Month March 30	Day Year
		/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	rial Cil 30	4c. County of Death
		Exami	iei	DORCHESTER GENERAL HOSPITAL	CAMBRIDGE		DORCHESTER
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	
		Director		212-68-6478 1XM 2□F 50 Yrs.	Months Days Hours Mill.	11/6/195	
		pug *		Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
		Aarylan f show	5	Maryland Wicomico Salisbu			1⊠Yes 2 □ No
3		tha 1	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
91		death with the Maryland ms 23e or 28e-f show rmust be notified at	<u>=</u>	510 Viewfield Drive	21804		USA
7		deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
5	ဖွ	after or Ite		1 V Nover Married 2 Married 1 Ves 2 No	1 Yes 2X No Specify:	riioari, etc.)	Specify: White
1	5-0036	within 72 hours ane. then "neturel", he Medical Exe	d by	3 Widowed 4 Divorced Year or Dates: Marines			
02	15	n 72	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing 16	6b. Kind of Business/Industry
XI	121	withi iene then	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	enter		Carpentry
P	d 2	illad I Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	
. 4	<u> a</u>	uld be Menta rkad tic ev	ToB	Paul Perry Manus Sr.	Wilhelm	ina Godri	ie
0	Maryland	short and N Is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rura	il Route Number, (City or Town, State, Zip Code)
3		and and marking markin		Paul P. Manus Sr/father 510	Viewfield Dr., S	alisbury,	MD 21804
P	Baltimore,	gas 1 and 2 should be filad within 72 hours after death with tha Maryla It of Health and Mental Hygiene. If item 27 is markad other then "neturel", or Items 23a or 28a-f show or other traumetic event, the Medical Examinar must be notified at		I - Buttat 2 Microstration 3 - Hemoval non-state	natory or other place)		oc. Location - City or Town, State
d	ξĦ	t. Partmen			Crematory 3/31,		Salisbury, MD
9	Bal	permit. Pagas 1 and 2 should be filad within Department of Health and Mental Hygiene. Important: If item 27 Is marked other then any injury or other traumetic event. The Magnee.		21. Sona of Funeral Pervice Licensee	olloway Funeral Ho	ome Profe	essional Association
				23a. Jart1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause or each line.	OUT SHOW HILL RO.	Salisbur	-V. MD 21804
		Dhysisian	(Immediate Cause (Final	F the Liver	. ,	Interval Between Onset and Death
U	1	Physician /Medical		disease or condition resulting in death) a	1 116 FIRST		
		Examiner		Hengtitis C			
		P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
		xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	760,	e a	cal E	Due to (or as a consequence or).			
	687	0 8 0		d			
	Box (cartif nding use a:	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
	ă	death e atter	iclar	in the past 12 months? 1 No. 3 No. 4 Pregnant at time of death 5]Ectopic pregnancy] Other <i>(specify)</i>		Month Day Year
	P.O.	tt the by the tache	hys	9 ☐ Unknown			
4		The law requires that the death cardifical ate has baen signed by the attending phypage 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.		cco use contribute to the cause of death?
	Records,	equir sen si nould	Completed			1 ☐ Yes	2 Probably 4 □Unknown
W.	ě	law law las bu	nple			24a. Was an autopsy	24b Were autopsy findings available prior to completion of cause of
K	E	: The cate b	Co			performe 1 Yes 2	
40	Vital	icien certifi rector	Be	25. Was case referred to medical examiner Hospital: Hospital:	26. Place of Death		
1	of	ding Phys h. After this funeral dii	5.	1 Impatient 2 EH/Outpatien	t 3 DOA 4 Nutsing Hor	me 5 Resident 28d. Describe how	ce 6 ☐Other (Specify)
B	O	nding th. : Afte	tlor	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work? M 1 Yes 2 No		,
3	Division	Atter	ifica	3 ☐ Suicide 6 ☐ Could n the determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number,
18		tel or rs afte al Dir ed in	Certification;	a distribution of the control of the		Ony or Town,	Oluloy
N		To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	occurred at the time, date and place, a	and due to the cau	se(s) and manner as stated. e and place, and due to the cause(s)
		the thin 2. the f	Medical	one) and manner stated. 29b. Signature and title of certifier.	29c. License number		I. Date signed (Month, Day, Year)
)	5 × 5 S	_	M n	057290	230	3/30/05
	•	1808	8	30. Name and address of person who completed cause of death (Item 23a) (Type,			1,00,03
		17/2		Marks L. Garaa-Bunel, MD	503 A Muir SA	. Car	50 de MD 21613
		Sta	ite	31. Date filed (Month, Day, Year) 32. Prgistrar's Signature) (
		Registr	ar	MAR 3 1 2005	mak 1		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 For State
Registrar 3-31-05 Amend #'s8.18.Per Inform.P. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1:30 A.M. Coleman Edward Miller 2005 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 30 Birthplece (State or Foreign Country) 72 521-46-1916 July Minn. Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21114 USA 1664 Carlyle Drive #K 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No 49-53& I Yes, Give Year or Dates 1957-61 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4 Elementary/Secondary (0-12) Photo Processing Sales Photography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Coleman Miller Josephine Varr Vaars 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 193 Joaquin Road Dean D. Miller / Son Mammoth Lakes, CA. 93546 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crematory 03/29/2005 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licentee 6512 NW Crain Hwy. Bowie, MD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ine tentatio Cancer

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

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Director

"naturel", or items 23a or 28a-f ehov

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f ehov eny injury or other traumatic event, the Medical Examinat must be notified at

Baltimore, Maryland 21215-0036

use as the burial-transit

or Attending Physician: The law requires that the death certificate be executed the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific upletely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

State

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Physician/Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	stack	ive	piranonan	n d	iseas	e	
nysician/Me	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnant 1 Live birth 2 Fete 4 Pregnant at time of c	ldeath 3 □E	Ectopic pregi Other <i>(speci</i>			2	3d. Date of delive Month	ry Day Year
Completed by Pt	Part II. Other significant conditions co	ntributing to death but not res	ulting in the und	derlying caus	se given in Part I.	24a.	\sim	No 3 Proba	osy findings available apletion of cause of
a	25. Was case referred to medical				26. Place of Dea	th (Check	only one)		
ToB	examiner? 1 ☐ Yes 2 No	Hospital: npatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome 5	Residence 6	Other (Specify	•)
	27. Manner of Death 15 Natural 5 Pending 2 Accident investigation	28a. Tate of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work? 1 □ Yes 2 □ No		ribe how injury		,
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At h building, etc. (Specific	ome, tarm, stree y)	at, factory, o	ffice	28f. Locat City	ion (Street and or Town, State)	l Number or Rural	Route Number,
Medical (29a. Certifier Certifying Phy (Check only one)	sician: To the best of my knowner: On the basis of examinating and manner stated.	wledge, death outlined	occurred at to estigation, in	he time, date and place my opinion, death occu	, and due to	the cause(s) a time, date and	and manner as sta place, and due to	ated. the cause(s)
Me	29b. Signature and title of certifier			29c. L	icense number		29d. Date	signed (Month, L	Dey, Year)
	1				11 a Com 11				

Dryx, Glen Burne no 2,06).

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)
MAR 2. 9 20

and addre is o person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of Maryla		artment of H			jiene og. No.	5 1262	3
	Physicia	an	Decedent's Name (First, Middle, Las		lower			2. Date of Dea Month Apr 6, 2	th POPE	3. Time of Death	M
	/Medic Examin		Grace R 4a. Facility Name (If not institution, give		lowei	4b. City, Town, or	Location of Death	Αρι 0, 2	4c. County of		
			Memorial Hospital			Cumberl			Allegar	ny	
	Funeral Director		5. Social Security Number 6. Social 176-18-4975	7. Age (<i>In yr</i> s	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Nov 25	1921	9. Birthplace (State or Fore	ign
	ס		Usual Residence of Decedent		ity. Town or Lo				,	10d. Inside City Lim	
	Maryla f show	jo	MD 10b. County Allegan	1		perland				1y□Yes 2□!	
	th the	lrect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W		
	s 23a	ral	12510 McMullen H				21502		US		
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel; or items 23a or 28a-f show or other traumatic event, the Mudical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2□ No If Yes, Give X Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	Ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White	
5	72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of Bus	siness/Industry	
72	iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	homen)		own hom	e	
Maryland 21215-0036	should be filed nd Menta! Hyg rmarked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) William Rutter				18. Mother's Name	e (First, Middle, I)	
	and 2 shouealth and N n 27 is mai		19a. Informant's Name/Relationship (7 Charles Mower	ype, Print) husband		ng Address (Street a		al Route Number Cumb		MD 21502	
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 li any injury or other tra once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crer	esition (Name of matory or other plac morial Park	e)	0ate 4/8/2005	20c. Location - C Cumber	City or Town, State	
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licen	1. Scarod	D- 22	2. Name and Address Scarpelli 108 Virg	i Funeral Ho inia Avenue		and. MD 2	1502	
To the second	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only- lmmediate Cause (Final disease or condition resulting in death)	cations that caused the dea he cause on each tine. a. Concestive Due to (or as a conse	Heart	er the mode of dyin				Approximate Interval Between Onset and Death 2 months	
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.O. Box 6	death certif e attending ed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	at death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year	
Q	quires that n signed b uld be deta	b	Part It. Other significent conditions of Renal Failure	ontributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			bute to the cause of death? 3 Probably 4 Unknow	vn
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Vita	Physicien: The this certificate har al director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat				
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	To the within 2 To the complete	Σ	29b. Signature and title of certifier	11 -	8/	29c. License		2	9d. Date signed	(Month, Day, Year)	
7			30. Name and address of person who	completed cause of death (Its	m 23a) (Tyne	D3328	0		April 6,	2005	
	8		Sunil Gupta, M.D				d, MD 21	1502			
	Sta Registr		31 Date filed (Month, Day, Year)	32. Segistrar's Sign		med !					

			For State of Maryland / Depart	tment of Health and M ificate of Death		ene () ()	5	126	24
		M	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		Year	3. Time of	Death
	Physici /Medic		Margaret (NMN) Moisse		April 8,			8:00	\mathbf{P}^{M}
	Examin		4a. Facility Name (If not institution, give street and number)	b. City, Town, or Location of Death		4c. County of	Death		
				Frederick		Frederi			
	Funeral		1 N 2 N =	If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min.	8. Date of Birth (Month, Day, Oct. 8,	rear)	Country	ce (State of	r Foreign
	Director		578-52-3630 97 Yrs. Usual Residence of Decedent		UCL. 0,	1907	Germai	ny	
	yland		10a. State 10b. County 10c. City, Town or Local	tion			10d	I. Inside Cit	y Limits
	a-fat	ictor	Maryland Frederick Frederick					1 ☐ Yes	2 ∑ №0
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of Wh	at Country	/?	
	23a		5522 Camelot Court	21704	US	SA			
	tems	Funeral	Armed Forces?	is Decedent of Hispanic Origin? (Spe 'es, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)		- American White, etc		
36	within 72 hours after death with the Maryland ene. than *natural', or items 23a or 28a-f ahow its M. olic. Ex., "ither", unt be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ 3 🛣 Widowed 4 ☐ Divorced Year or Dates:	Yes 2፟፟M No Specify:		Specify:			
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פ	e file al Hyg l othe vent,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name					
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Maryland	2 sho and I amma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rura	l Route Number,	City or Town, S	tate, Zip Ce	ode)	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items 23a or 28a-f ahow amy njury or other traumatic event, I're M. Alic. Ex., either is set be notified at once.			Name and Address of FacilityKeen 196 East Church St				ral Ho 2170	
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	Vabeatal Dibease				year	2
	LAdillillei	L	Sequentially list conditions, b.						3
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cases of injury. Due to (or as a consequence of): Cause (Disease or injury)				-		
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$\mathbf{\alpha}$	death e atte d for	icia	in the past 12 months? 1 Vac 2 N No. 4 Pregnant at time of death 5 0	ctopic pregnancy hther (specify)		Monti		ay Y	ear
O.	that the de led by the a detached f	hys	9 ☐ Unknown 9 ☐ Unknown						
ري ص	res tha igned be det	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did toba	icco use contrib	ute to the	cause of de	ath?
rd	w require been st	ed			1 ☐ Yes	2 X No 3	☐ Probab	ly 4 ⊡Ur	nknown
Records,	e faw re ha's be je 2 sho	Completed			24a. Was an autopsy	24b. We	ere autopsy	y findings a	vailable
	ysician: The is certificate hadirector, page	mo:			performe	ed? de:	ath? Yes 2		use or
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death					
		To	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4X Nursing Hon	ne 5 🗆 Residen	ce 6 □Other	(Specify)		
0	ding P. h. After t		27. Manner of Death 1 XNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c, Injury at 2 Work?	8d. Describe how	injury occurred	1		
sio	death death stor: A	cati	2 Accident investigation	M 1 Yes 2 No					
Division of	l or Atten after deatl Director: I in by the	Certification;	4 Homicide 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	8f. Location (Stre City or Town,	et and Number State)	or Rural R	loute Numb	er,
	pital ours a eral (29a. Certifier 11X Certifying Physicien: To the best of my knowledge, death or	coursed at the time date and also	and also a second				
	Hos 24 hc Fun stely (Medical	29a. Certifier (Check only one) 1 ★ Certifying Physicien: To the best of my knowledge, death or (Check only one) 1 ★ Medical Examiner: On the basis of pramination and or investance and manner stated.	ccurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cau ed at the time, dat	ise(s) and manr e and place, an	er as state d due to th	ed. e cause(s)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of pertition /	29c. License number	290	d. Date signed (Month, Da	y, Year)	
)	⊢s⊢ö		+ Karfman	D-13971	۸	ril 9,	2005		
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri		Ap	LLL 7,	2003		
	6		Robert L. Kaufmann, MD, 300 West Ninth		k, Maryl	and 21	701		
	Sta	te	31. Date filed (Manth Ray Year) 2005 Registrar's Signature						
	Registr	ar	WINTO TOOL DE PROPERTY						

			1 - For State Registrar	State of Man		artment of rtificate of			ene 0 0 5	12625
ľ	Physici /Medio		1. Decedent's Name (First, Middle, La	Y MARTIN), Vr.			2. Date of Death Month	Day Year 7 200	3. Time of Death 302 PM
,	Examin		4a. Facility Name (If not institution, giv	40KIAL		1+AV	or Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. S 214–24–8070	7. Age (II	n yrs. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day, Y 8/8/1928		thplace (State or Foreign ountry) ISylvania
	with the Maryland a or 28a-f show be notified at	ř	10a. State 10b. County MD Harfo		c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 3/☐ No
	the M	Director	10e. Street and Number	Lu	navre (de Grace		100	. Citizen of What C	**
	3a or		4116 Webster La	pidum Road		21078		1.09	USA	ountry:
	death ms 23 r. r.ust	Funeral	11, Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of	Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
30	or Ite	by Fu	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	Named Porces? Named Porces? No If Yes, Give Year or Dates: Www.	пт	1 ☐ Yes 2 ☐ XNo	ban, Mexican, Puèrto Specify:	Hican, etc.)	Specify: Wh	
9500-c	"naturel",	ted b	15. Decedent's E	ducation	16a, Dece	edent's Usual Occu	pation	16	ib. Kind of Business	
2	be filed within 72 hc lal Hygiene. d other then "natur event, In e Medical	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	_		e during most of working ed)	ng		ŕ
7	filed wi Hygien Sther th	Con	8		Ammo T	ester Or	1		Civil Ser	vice
and		o Be	17. Father's Name (First, Middle, Last) William E. Mart				18. Mother's Name	(First, Middle, Ma M. Parri		
\geq	d 2 should th and Men 7 is marke traumatic	^L	19a. Informant's Name/Relationship (19b. Mail	ing Address (Stree	at and Number or Rura			Zip Code)
, Na	s 1 and 2 f Health a item 27 is other tra		Patricia A. Mart	_ · +			ridum Road,	Havre de G	trace, MD 2	1078
ore	of He fiter		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐		20b. Place of Disp cemetery, cre	matory or other pla	ace)		c. Location - City or	
baitimor	t. Pag rtment rtent: I		'4 □Donation 5 □ Other (Specif				rdens 4/11	/2005	Fallston,	MD
e n	permit. Pag Department Importent: I eny injury o once.		21. Signatural Funeral Service Licer	1. hovelre	Go H		eral Home, Inc			PA 17314
,	Pny sicia n		23a. Part1. Entertive disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the one cause on each to e.	death. Do not en	ter the mode of dy	ing, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Dus to (or as a co	onsequence of):	11/14	CHUM			PIPIEDIAIT
	Examiner	er	Sequentially list conditions, if any, soung to immediate cause. Enter Underlying	b. Due to for as a re	wassesses all					
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events		or reacting the Oil.					
Ď.	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as a co	onsequence of):					
00/8	icate be executed physician and s the burial-transit	dical		d.						
o X	death certificate e attending phys od for use as the	ian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of de	iven
<u>.</u>	death le atter ad for u	iciar	in the past 12 months?	1☐Live birth 2☐ 4☐Pregnant at tim		⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	ey		Month	Day Year
r S	at the d by th etache	Physicia	9 Unknown	9 Unknown						
ds,	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	CKIENSION	ovresulting in the t	inderlying cause gi	iven in Part I.	23e. Did tobac		the cause of death? obably 4 \(\bigcap\)Unknown
ecords	law req as beer 2 shou	ompleted	TACK	Pagel Chole	STERN	ARION	nsclerosis	24a. Was an	24b. Were au	itopsy findings available
Ē	The ate h page		AlZ	HEIMERS		7110000	20.000	autopsy performer 1 ☐ Yes 2	d? death?	completion of cause of
V 11.28	cian: ertifica sctor,	BeC	25. Was case referred to medical examiner?				26. Place of Death			
5	Shysi this o	ု	1 ☐ Yes 2 ☑ No	Hospital:	2 R/Outpatie	nt 3L DOA			e 6 Other (Spe	cify)
	ding Physician: h. After this certific funeral director,	Certification;	27. Manne of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wo	ork? ⊇Yes 2 □No	8d. Describe how	injury occurred	
UNISION	Attendi r death. sctor: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury	At home, farm, st			8f. Location (Stree	at and Number or Ru	ıral Route Number,
5	s afte	Cert	4 Homicide	building, etc. (5	specity)			City or Town, S	State)	
	To the Hospitel or Attending Physician: white 24 hours after deals To the Funarel Director; After this certification in the funeral director, completely filled in by the funeral director,	edical	29a. Certifier (Check only one)	ysician: To the best of miner: On the basis of example and manner stated	amination and/or in	th occurred at the to	ime, date and place, a opinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To th within To the compl	Me	29b. Signature and title of certifier	1/1/	/	29c. Licen	se number	29d.	Date signed (Mont	h, Day, Year)
	8) //// //	Adans		14	0922		4/7/5	
1	LIN		30. Name and address of pers. who	come ted come se of death	(Item 23a) (Type,	Print) Mion As	0922 18 HAUREC	Al-Asso	100 2	1078
Ì	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 2005	32. Registrar's	Signature	TUN IV	C 117 VIC C	CONVICE	() () () () () () () () () ()	
	ricgisti	ar .	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	parties de	P ARSA	e P				

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Wm. Emony Martin Jr.

	**		T = For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H			iene	5 12626
			1. Decedent's Name (First, Middle, Last))				2. Date of Dear	th	3. Time of Death
	Physici /Medic			Philip	Eugene May	, Sr.		April 1		5:45 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	1	4c. County of	
			10630 Keysville	Road		Emmit			Fre	derick
	Funeral		5. Social Security Number 6. Sec	7. Ag XM 2□F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)1939 9). Birthplace (State or Foreign Country)
	Director		217-36-4391	BLIVI ZUF	65 Yrs.			October		Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	daryl f sho	ō	Maryland Frederic	c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Emmits	huma			1 ☐ Yes 2X No
	the 128a-	Funeral Director	10e. Street and Number			10f. Zip Code	Durg	1	0g. Citizen of Wha	at Country?
	3a or		10630 Keysville B	Soad.		217	27			,
	death ms 2	era		12. Was Decedent	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	- : 	pecify Yes or No-	U.S. I	American Indian,
9	atter or Ite	표	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔀	No	9.0		o Rican, etc.)	Black,	White, etc.
8	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	White
5	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occupa	ation	kina	16b. Kind of Busin	ness/Industry
7	ithin ner ner	du	Elementary/Secondary (0-12)	College (1-4or	5+) life.	kind of work done of DO NOT use retired)	9		
7	led w lygier her th		11			Mechanic			Auto Re	epair
and	build be filed within 72 hours atter death with the Maryland Mental Hygiene. Arked other than "natural", or items 23a or 28a-f show atte event, the Medical Exactines has been integral	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, I		
3	should and Men marke	ပ	William H. May,					nda L. Re		
Maryland 21215-0036	12 st h and 7 Is n traun		19a. Informant's Name/Relationship (Ty			ng Address (Street a				
_ _	s 1 and 2 should be filed within 72 hours atter death with the Marylan if Healint and Mental Hygiene. If Healint and Mental Hygiene "natural", or thems 23a or 28a-f show them 21 is marked other than "natural", or thems 23a or 28a-f show other traumatic event, it a Medical Exacting transition of the notified at	- 1	Elsie E. May (V	Wife)	20b. Place of Dispo	O Keysvil	Le Rd. Ei	Date	 MD 217 20c. Location - Cit 	
סר	ages nt of I : If it		1 ☐ Burial 2 X Cremation 3 ☐ R	lemoval from State	cemetery, cre	matory or other plac	1	2005		
Baltimore,	it. Printme	-	'4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	00		rg Cremato 2. Name and Addres				arg, Maryland
Ba	perriit. Pages 1 and 2 Dep-riment of Health a Jmportant: if Item 27 li any injury or othar tra once.		1.00	" — .	1.101414	2525 Brad			is Funer	
		_	23a. Part1. Enter the disease, or compli	ications that caused						Approximate
	D. ::		snock, or heart failure. List only or Immediate Cause (Final	ne cause on each li	ne.					Interval Between
1	Physitian /Medical		disease or condition resulting in death)	ENDS	a consequence of):	NON HO	DGUKI	NS LYO	ufHan	# 4 CK
	cate be executed XX hysician and XX the burlat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	INSLY	mpite	MA		9 manys
8760,	icate be physical the bu	dical		1						
O. Box 6	ath certiti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	,
Records, P.	ulres that the de	by	Part II. Other significant conditions cor	stributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	_	ute to the cause of death? ☐ Probably 4 ☐ Unknown
Ö	w require	Completed						24a. Was a	n 24b Wer	re autopsy findings available
æ	he lay	щ						autops perforn	y prior nęd? deat	r to completion of cause of th?
		e C	25. Was case referred to medical				00 Di/ D		V .	Yes 2 No
5	Physician: The la r this certificate has ral director, page 2	0 8	examiner?	lospital:	ent 2 ER/Outpatier	othe Othe		th Check only on	nce 6 🗆 Other ((C
Division of	ng utte	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time o	f 28c. Injury Work	4 🗆 11013/11g 11		w injury occurred	<i>Specify)</i>
Divis	To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (St. City or Town		or Rural Route Number,
	To the Hospital within 24 hours and to the Funeral completely filled	edical (29a. Certifier (Check only one) 1 Certifying Phys	sicien: To the best ner: On the basis of and manner st	of my knowledge, deat f examination and/or in ated	h occurred at the time vestigation, in my di	e, date and place, binion, death door	and due to the ca	tuse(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To t To t Com	Σ	29b. Signature and title of ortifie	Many	1. Colo	29c. Licens	number 440	25 > 25	d. Date signed (N	fonth, Day, Year)
	,		BONITAJ, K	RELUPI	EL-PORT	TERDO	0 '	-/	>4/04	105
	15	r	30 Name and address of person who co	mpleted cause of d	leath (Item 23a) (Type,	Print)	(52 WO	HER	STREET
	-04		31. Date filed (Month, Day, Year)	2 Range	ar's Signature	TIER	D.C.TI	4uRu	ONT,	MD21388
	Sta Registra		APR 1 2 2005	A Constant	1 Apos	le				

hysic		Registrar 1. Decedent's Name (First, Middle, Las	t)	aryland/D f per ME					2. Date of De	eath	- 10 (D)	3. Time of Dea
/Medi		James Poi	ffenberger	Mause					March	Day 7	2005	5:00 p.
Examir		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	of Death		4c. Cou	unty of Death	
		9811 Mt. Tabor Ro					ville			Fr	ederi	
uneral		5. Social Security Number 6. Se	ex 7.Ag V∏M 2□F	e (In yrs. last birth 83 Y	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June 4,	rth ay, Year)	9. Birth Cou	place (State or Fo intry) y land
rector		228-14-5142 Usual Residence of Decedent		65	<u>. </u>				pulle 4,	1921	Mar	yrand
MOL		10a. State 10b. County		10c. City, Town	or Location		·-···					10d. Inside City L
r 28a-f show	ctor	Maryland Frederic	ck	Myersv	ille							1 Tes 2
0 💥	Director	10e. Street and Number			10f. Zip					10g. Citizen	of What Cou	untry?
23a		9811 Mt. Tabor Ro				1773				USA		
ltem:	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Orig n, Mexican	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	0- 14. [Race - Amer Black, White	
l', or	by F	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:	WWII	1 🗆 Yes	2 X No	Specify:			Spe	ecify: Wh:	ite
atura		15. Decedent's Ed	ucation		ecedent's Usua					16b. Kind o	of Business/I	ndustry
an "n Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5		Give kind of wo ife. DO NOT u	rk done d se retired	during most)	of work	ing			
ar than	Con	12	4		ief Cle	erk				MD Hou	se of	Delegat
is marked othar aumatic avant, I	Be	17. Father's Name (First, Middle, Last)	C						e (First, Middle,			
arkec natic a	2	John David Mause							atherin		`	
7 is n traun		19a. Informant's Name/Relationship (7) Wilma Mause/wife	ype, Print)						al Route Numb yersvil			
item 27 is marke other traumatic	1	20a. Method of Disposition		20b. Place of D			11001		Date		on - City or T	
t: If it y or o		1 ☐ Burial 2 🎇 Cremation 3 🗆		Smithsh	crematory or o	ther place			2005			Marylan
Importent: If ite any injury or ot once.	i	' 4 □ Donation 5 □ Other (Specify	*	0	22. Name an					Main		
any ir		1/21/20	1. 1-		Ricket					rsvill		
-		23a. Part1. Enter the disease, or color shock, or beart failure. List only of	lieations that caused	the death. Do no	t enter the mod	le of dying	g, such as	cardiac				Approximate
sician edical miner		Immediate Cause (Final	nie cause on each in	10.						/		Onset and Dea
		disease or condition resulting in death)	Due to (or as	a consequence of	pres					/		days
miner		Sequentially list conditions	o chronic	collecti	tes muit	the 1	urs6	1	(n)			6 moult
	iner	Sequentially list conditions, and backing to investigate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a nonsequence of					11/6	,	T.	
ician and , burial-transit	Examiner	that initiated events resulting in death) Last	c. Barapl	a consequence of					Y/4	1		is .
physician the burial	Ē		() Due to ter as	a gonsequence or	i				DROVED BY MED	IICAL EXAMINE	H	
the	dicai		d				DTIFICA	TION AP	BONED BY			
attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy			CERTIN				Date of deliv	100/
d for	iciai	in the past 12 months?	4☐Pregnant at	2 Fetal death time of death	3 ☐ Ectopic pr 5 ☐ Other (sp						Month	Day Year
ed by the detached	hys	9 ☐ Unknown	9□ Unknown									
gned be det	by P	Part II. Other significant conditions co	entributing to death b	ut not resulting in t	ne underlying c	ause give	n in Part I.		23e. Did to	obacco use c	ontribute to t	the cause of death
500	ed								101	Yes 2√□No	3 Proi	bably 4 ∏Unkr
en sigr ould be	pie								24a. Was		b. Were auto	opsy findings avai
s been s 2 should									perfo	rmed? 2 □ No	death?	ompletion of cause 2 No
ate has been s page 2 should	Con	25. Was case referred to medical						of Death	Check on o	one		
ate has been s page 2 should	Be Completed	eyaminer?		nt 2 ER/Outp	atient 3 DO		4 LI INUI		me 5 Hesio			fy)
this certificate has been s al director, page 2 should	To Be	examiner?	Hospital: 1 ☐ Inpatie		18 Of 2	8c. Injury Work	? _	1.0	28d. Describe r Passen g			Police
fter this certificate has been s ineral director, page 2 should	To Be	examiner? 1 Yes 27. Manner of Death Control 5 Pending	28a. Date of Inju- (Month, Da)	Y Year) 28b. Tin Inju	iry							pent
fter this certificate has been s ineral director, page 2 should	To Be	examiner? 1 Yes 27. Manner of Death	28a. Date of Injui (Month, Day 04/13/19	71 Unkr	own M	1 3 ₹ Y	/es 2□N	.0	that st	Street and Nu	mher or Pur	al Davida Alumbar
fter this certificate has been s ineral director, page 2 should	To Be	examiner? Type Yes 27. Manner of Death Death Solution Solution Type Matural Solution Sol	28a. Date of Injun (Month, Day 04/13/19 28e. Place of Injun building, etc.	Unkriury - At home, farm	own M	1 3 ₹ Y	∕es 2∐N		281. Location (S City or Tox	Street and Nu vn, State)	mber or Run	al Route Number,
fter this certificate has been s ineral director, page 2 should	Certification; To Be	examiner? 1 Yes 27. Manner of Death	28a. Date of Injun (Month, Da) 04/13/19 28e. Place of Injun building, etc. roadway	Unkn	, street, factory	1 TY	e. date and	place.	City or Tow I-70, Mo	Street and Nu vn, State) ntgome	ry Co	al Route Number, unty, MD
fter this certificate has been s ineral director, page 2 should	Certification; To Be	examiner? 1 Yes 27. Manner of Death	28a. Date of Injunction (Month, Day 04/13/19) 28e. Place of Injunction (Month, Day 04/13/19) 28e. Place of Injunction (Month)	Unkn ury - At home, farm c. (Specify) of my knowledge, control of my	, street, factory	1 TY	e. date and	place.	City or Tow I-70, Mo	Street and Nu vn, State) ntgome	ry Co	al Route Number, unty, MD
fter this certificate has been s ineral director, page 2 should	To Be	examiner? 1 Yes 27. Manner of Death 2X Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Exam	28a. Date of Injun (Month, Da) 04/13/19 28e. Place of Injunded building, etc. roadway visician: To the basis of iner: On the basis of	Unkn ury - At home, farm c. (Specify) of my knowledge, control of my	death occurred or investigation,	1 TY	e, date and inion, deat	place.	City or Tow 1-70, Mo and due to the ed at the time.	Street and Nu vn, State) ntgome	mber or Run ery Con manner as s se, and due t	al Route Number, unty, MD stated. o the cause(s)
this certificate has been s al director, page 2 should	Certification; To Be	examiner? Yes 27. Manner of Death Thattural 2X Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) Check only one)	28a. Date of Injun (Month, Da) 04/13/19 28e. Place of Injunded building, etc. roadway visician: To the basis of iner: On the basis of	Unkn ury - At home, farm c. (Specify) of my knowledge, control of my	death occurred or investigation,	1 TYY , office at the time in my op	e, date and inion, deat	place.	City or Tow 1-70, Mo and due to the ed at the time.	Street and Nu wn, State) Intgome cause(s) and date and place	mber or Run ery Con manner as s se, and due t	al Route Number, unty, MD stated. o the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM #8tarEnd INTER GRAND AND A PROPERTY OF Health and Mental Hygiene, amend item# 1- State Registrar 26 per phy., bg 3/30/05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Yeer March 26, 8:20AM M Julia 2005 Anne Northam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 30126 Peggy Lane Princess Anne Somerset If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 6-30-1939 irrhplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 2 F Yrs. Director Virginia 215-36-0374 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23e or 28a-f ehow other treumstic event. Its Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Somerset <u>Princess Anne</u> 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 30126 Peggy Lane 21853 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes at No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "I any injury or other treumatic event, the Next Elementary/Secondary (0-12) College (1-4or 5+) 12 Dept. of Social Service none Case_Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Soula Custis Bull Audrey Mears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Thomas Northam/Husband 30126 Peggy Lane, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) Beechwood Cemetery 03/30/2005 Princess Anne, Maryland Signature of Funeral Service Livensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 Part1. Enter the disease, or complications haveaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. . Part1. Enter the disease, Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) metastating Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Completed Be ٩ Certification; filled in by the

1 Natural

2 Accident

4 Momicide

3 Suicide

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

5 Pending investigation

6 ☐ Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ En 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 No

1 ☐ Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number 2

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person, no completed cause of death (Item 23a) (Type, Print)

Dr. Charles Stegman, 30434 Mt. Vernon Road, Princess Anne, MD 21853 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registrar's Signature Elven & Apoll

DHMH 17 Rev 1/2001

Hospitel or Attending Physicien:

the

this

After

within 24 hours after death. To the Funerel Director: A

			State of Maryland / Dep 1- State Unpend Item 23a,pt.II,27,28a-f	artment of Health and Mental H er me 6842 4-14-05 tas erlificate of Death	ygiene 005 12629
			Decedent's Name (First, Middle, Last)	2. Date of I	
	Physici /Medio		LATISHA M. NEWTON	Apri	1 2, 2005 08:59 P. ^M
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
-			Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Laurel // If Under 1 Year If Under 24 Hrs. 8, Date of B	Prince George's Birth 9. Birthplace (State or Foreign
2	Funeral Director		214-86-0196 1□ M 2♥F 33 Yrs.	Months Days Hours Min. (Month, June	Day, Year) Country) 22,1971 Maryland
(A)			Usual Residence of Decedent		
	ith the Marylan or 28e-f show is notified at	_	10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits 1 □X es 2 □ No
	he M 28e-f	Director	MD Prince Geo B	eltsville 10f. Zip Code	10g. Citizen of What Country?
	with t		11605 Old Baltimore Pike	20705	U.S.A.
	ms 23a	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian,
ဖွ	s I and 2 should be filed within 72 hours after deeth with the Maryland Fleatth and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other then "natural", or Itams 23a or 28e-1 show other treumatic event, the Medical Examiner must be notified at		Armed Forces? 1 ☐ Yes 2 ☐ Morried If Yes, Give	If Yes, specify Cuban, Mexican, Puèrto Rican, etc.) 1 ☐ Yes 2 😽 No Specify:	Black, White, etc. Specify: Black
5-0036	72 hours "natural",	d by	3 Widowed 4 Divorced Year or Dates:		16b, Kind of Business/Industry
	n 72 i	oiete	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	160. Kind of Business/Industry
2121	s withir ilene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Disabled	None
	2 should be filed with and Mental Hygiene Is marked other thai eumatic event, Ibe B	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	fle, Maiden Sumame)
<u>Va</u>	should be nd Mental marked c	10 E	Eddie L. Newton		L. Simms
Maryland	2 sho n and lsm reum		Grand-	ling Address (Street and Number or Rural Route Num	1 18406 THEORY COLORS
	1 and 2 Health em 27		Malinda O. Adams (Mother) 870 20a. Method of Disposition 20b\Place of Disp	2 Timber Oak In, Lau position (Name of ematory or other place) Date	20c. Location - City or Town, State
20	Pages nent of th ant: If Ite				Laurel, MD
Baltimore,	. 5 9 .5			22. Name and Address of Facility Snowden	
ä	permit. Depart Import any in		George J. Susual 2	46 N. Wash. St., Roc	kville, MD 20850
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory	r arrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a Cocaine intoxicati	.on	Onsat and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
	145	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events C		1
oʻ	or Attending Physicien: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the ettending physicien and in by the funeral director, page 2 should be detached for use as the buriat-transit		resulting in death) Last Due to (or as a consequence of):		
8760,	ate be rhysici the bu	Physician/Medical	d		
9 ×	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Вох	leath certifica ettending ph I for use as th	cian	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	Month Day Year
P.O.	that the di ed by the detached	hysi	9 Dunknown 9 Unknown		
	es tha igned l	by P	Part II. Other significant conditions contributing to death but not resulting in the	arraotty mig daugo giver mir arriv	d tobacco use contribute to the cause of death?
Vital Records,	v require been si should b		Seizure disorder	11	Yes 2 No 3 Probably 4 Munknown
ec	has be	Completed		24a. W	as an topsy from a 24b. Were autopsy findings available prior to completion of cause of death?
<u>=</u>	: The			1 XYes	2 No 1 Tes 2 No
Vits	stclen: Th certificate rector, pag	o Be	25. Was case referred to medical examiner? 1X Yes 2 □ No Hospital: 1 □ Inpatient EP/Outpatie	26. Place of Death (Check onleant 3 DOA Other: 4 Nursing Home 5 Re	
ō	Phys or this oral di	-	27 Manner of Death 28a Date of Injury 28b. Time	of 28c. Injury at 28d. Describ	e how injury occurred unk
ion	ttending F death. ctor: After / the funer	ation	1 Natural 5 Pending 4-2 05, Day Year) 8:25 found found	Work? 1 □ Yes 🛣 No	
Division of	r Atte er der recto	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ★ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location City or 1	(Street and Number of Rural Route Number, Fown, State) / 30 / Contee Rd.
	urs aft rel DI		found in house	Laure	, Maryland
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledicai	29a. Certifier (Check only one) 1 □ Certifying Physicien: To the best of my knowledge, dea (Check only one) 1 □ Certifying Physicien: To the best of my knowledge, dea (Check only one) 1 □ Certifying Physicien: To the best of my knowledge, dea (Check only one) 1 □ Certifying Physicien: To the best of my knowledge, dea (Check only one)	ith occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time.	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
	o the	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	->-0		Janho By Mars & Mp	OCME	April 3, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type		timoro Morrel and 01001
			31. Date filed (Monthly) York 2005 32. Egistrar's Signature		timore, Maryland 21201
	Sta Registr		31. Date filed (Monthly, Yorl7 2005) 32. Segistrar's Signature	puli	

			1 - For State Registrar	ate of Marylar	nd / Depa		Health ar	nd Mental		ne 0.05	12630
1	9		Decedent's Name (First, Middle, Last)					2. Date	of Death		3. Time of Death
	Physici /Medic		Betty Jane Otto					Month		Day Year	9:05 a M
	Examir		4a. Fecility Name (If not institution, give street	and number)		4b. City, Town,	or Location of			4c. County of Death	
			Holy Cross Hospital				er Spri			Montgomer	у
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Yea Months Day	r If Under 24 s Hours	Hrs. 8. Date of (Mont	of Birth h, Day, Ye	9. Birth Cou	place (State or Foreign intry)
l l	Director		Usual Residence of Decedent	83	Yrs.			Jan.	13,	1922 Penr	sylvania
land	Mo TI		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
Many	두글	ţ	Maryland Montgome	ry	Wheat	on					1 ☐ Yes 2 K No
h the	r 28g	Director	10e. Street and Number		-	10f. Zip Code			10g.	Citizen of What Cou	intry?
th Wi	23a (ai	2715 University Blv	d, West, #	322	20	902			USA	
r dea	tems F E	Funerai	11. Marital Status 12. W	as Decedent Ever in U	.S. 13.	Was Decedent of	Hispanic Origin ban, Mexican, I	n? (Specify Yes of Puerto Rican, etc.	or No-	14. Race - Ameri Black, White	
hours after death with the Maryland	o'	by F	If	☐ Yes 21☐ No Yes, Give ear or Dates:		1 □ Yes X □ N	o Specify:			Specify: Whi	
	ital hygisne. id other then "naturel", or items 23a or 28a-1 show event, the Medical Evantiver must be notified at	edt	15. Decedent's Education		16a. Dece	dent's Usual Occ	ination		16h	Kind of Business/Ir	ndustry
filed within 72	Medi	Completed	(Specify only highest grade com	pleted) ollege (1-4or 5+)	(Give life.	kind of work don DO NOT use retii	e during most o ed)	of working	100	Time of Education	· duoiny
d wit	giene er tha	mo:	12	5/10g6 (1-401 5+)	Н	omemaker				Own H	Iome
d)	al Hygi d other svent, I	Be (17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, M.	iddle, Maid	en Sumame)	
pluo	and Menta Is marked reumatic ev	7	James T. O'Donnel				Mar	y Irvin			
d 2 sh	ls m		19a. Informant's Name/Relationship (Type, P.	_						y or Town, State, Zi	
1 and	Healthern 2	6.5	Carol J. Powell-Nava		-	And the second second		d, West		aton, Location - City or T	MD 20902
permit. Pages 1 a	1 = 1 = 1		1 X Burial 2 ☐ Cremation 3 ☐ Remov			sition (Name of matory or other pi aven Cemet		arch 29.			
H.	artmer ortent injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		-		- :	2005			ng,Maryland
реги	Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic erone.		Will EBouch	2	F1	rancis J 00 Unive	rsity B	ns Funer	cal H	ome Inc er Spring	,MD 20901
be executed	Medical the private transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events c.	Coronary An Due to (or as a conseq Pulmonary I Due to (or as a conseq Due to (or as a conseq	uence of): Edema uence of):	Disease		- CAMPANA			
the death certificate	attending p for use as	Physician/Med	in the past 12 months?	yes, outcome of pregna Live birth 2 Feta Pregnant at time of d Unknown	Ideath 3□	Ectopic pregnan Other (specify)	су		_	23d. Date of deliv Month	ery Day Year
law requires that the	been signed by the should be detached	by	Part II. Other significant conditions contribut Diabetes Mellitus,		_		iven in Part I.		Did tobacc	o use contribute to t 2⊠No 3 ☐ Prot	he cause of death?
aw rec	s bee	Completed							Mas an	24b. Were auto	ppsy findings available
The law	ate ha	mo							utopsy performed? es 2 13 4	death?	mpletion of cause of
	rtifica tor, p	0	25. Was case referred to medical				26. Place of	f Death (Check o		10 105	2 140
hysic	nis ce I direc	To B	examiner? 1 ☐ Yes 2 🔀 No Hospita	al: 1 🗆 Inpatient 2 🗀	ER/Outpatien	t 300A O	ther: 4 🗆 Nursi	ing Home 5□1	Residence	6 ☐Other (Specif	(y)
ng P	n. After this certificate has funeral director, page 2		27. Manner of Death 1 ★Natural 5 □ Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ury at ork?			jury occurred	
tendi	er death. •ector: A by the fu	cati	2 Accident investigation]Yes 2 □No	_			
or Al	Direc Direc in by	Certification;	4 Homicide determined 286	 Place of Injury - At he building, etc. (Specify) 	ome, farm, str	eet, factory, office	•	28t. Locati City of	on (Street or Town, Sta	and Number or Rura ite)	al Route Number,
To the Hospitel or Attending Physician:	within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 15 Certifying Physician (Check only 2 Medical Examiner: C	: To the best of my kno	wledge, death	occurred at the	time, date and p	place, and due to	the cause	(s) and manner as s	tated.
the H	the Fi	Medical	one) a	nd manner stated.	non and/or inv			occurred at the ti	.,		
To	Too Cou	2	29b. Signature and title of certifier	1 0:	Ca 11 -		se number			ate signed (Month,	
	١		rouino l	non	y		8965 		Ma	arch 26,	2005
			30. Name and address of person who complete Saima Khawaja, M.D.	/		•	#100, 1	Rockvil1	e, Mr	20852	
	Sta Registr		31. Date filed (Manth Cay, Y2") 9 2005	32. Régistrar's Signa	ture A	and I	•				
	gioti	THE STATE OF		1							

			1 - For State Registrar	State of Ma		artment of He rtificate of D	ealth and Men	tal Hygien	2005	12631
П	Physic	an	1. Decedent's Name (First, Middle, La	ist)				Date of Death Month Da	Vone	3. Time of Death
	/Medi		BERMA	LILLIAN	MILAM	OVERI	BY Ma	arch 26	2005	5:45 AM
	Examir	ner	4a. Facility Name (If not institution, gire			4b. City, Town, or Le	W	40	. County of Death	
			Hart Heritag				treet		Harf	
	Funeral Director			CTA OWN C	(In yrs. last birthday)		If Under 24 Hrs. 8. [Hours Min. 1	Date of Birth Month, Day, Year 17/19(9. Birth Coul)4 Mis	place (State or Foreign ntry) SISSIPPI
	aryland show		10a. State 10b. County		10c. City, Town or Lo	cation				Od. Inside City Limits
	Man 9-f sh	ģ	MD. Har	ford			Street			1 ☐ Yes 2 No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code	2000	10g. Ci	tizen of What Cour	ntry?
	23e	<u>a</u>	4537 Madonn	a Road			21154	Ur	nited S	tates
	r dez	ne	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13. \	Vas Decedent of Hisp f Yes, specify Cuban.	anic Origin? (Specify Mexican, Puerto Rica		14. Race - Americ Black, White,	an Indian,
36	or l	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		_ **	Specify:	.,,	Specify:	
8	72 hours after death with the Maryla neturel', or Items 23e or 28e-f shov dical Examinar must be notified at	d b			10. 5					White
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "neturel", or items 23e or 28e-f show event, the Medical Examiner manthe motified at	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	lent's Usual Occupation kind of work done duri OO NOT use retired)	on ring most of working	16b. K	(ind of Business/In	dustry
72		E O	Elementary/Secondary (0-12)	College (1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		uyer	De	nartmar	nt Store
b	ld be filed ental Hygi ked other ic event,	BeC	17. Father's Name (First, Middle, Last				8. Mother's Name (Fin			TO POOLE
Maryland	Mental Merked c	To B	James	Ferrell	Milar	n	Sadie	Lel	ia	Tatem
ary	d 2 should th and Men 7 Is marke treumatic	-	19a. Informant's Name/Relationship (Type, Print)			d Number or Rural Ro			
	1 and 2 Health tem 27 I		Corinne O. Mor	ris/Daugh	ter 453	7 Madonna	a Rd.	Street,	Md. 2	21154
Baltimore,	ges 1 and t of Healt if item 2		20a. Method of Disposition **Burial 2 Cremation 3	Bamoual from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Date		ocation - City or To	own, State
Ë	Pages ment of ent: If it ury or o		`4 □ Donation 5 □ Other (Special	y))			r. 3/30/	2005 Be	l Air.	Maryland
Salt	permit. Pag Department Importent: eny injury conce.		21. Signature of Funeral Service Life	see D	22	. Name and Address of	of Facility Jari	rettsvi	lle, Ma	ryland
	40 E 8 9		111. J.	en lung.	I	E.G. Kur	tz & Son	Funera	l Home,	P.A.
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each fine. a	ronamy	Arter	such as cardiac or res			Approximate Interval Between Onset and Death
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	death certificate be executed e attending physician and ad for use as the burial-transit	Examiner	that initiated events	с.						
Ó,	e exe ian a urial-l		resulting in death) Last	Due to (or as a o	consequence of):					
8760,	ate b hysic the b	dical		d						
9	leath certific attending p I for use as I	Mec	IF FEMALE:							
Вох	attenc attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy		\$1	23d. Date of delive Month	ry Day Year
o.	the de y the iched	ysic	1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death 5∐	Other (specify)				ouy real
Δ.	that the de led by the a detached	/Ph	Part II. Other significant conditions of	ontributing to death but r	not resulting in the un	derivina cause given i	in Part I. 2	23e. Did tobacco ı	use contribute to th	e cause of death?
Vital Records,	90	d by				, ,	ii ii			ably 4 nknown
00	w require been si should t	Completed						24a. Was an	1	
Re	he lav e has age 2	шс						autopsy performed?	prior to con death?	osy findings available apletion of cause of
	en: T	0	25. Was case referred to medical					☐ Yes 2 No	1	2 No
>	ysici s cer direct	ToB	examiner? 1 ☐ Yes 2 No	Hospital:	2 ER/Outpatient	Cut	 Place of Death (Che Vursing Home 			25.5 Fed
0 (g Ph		27. Manner of Death	28a. Date of Injury (Month, Day Y		28c. Injury at Work?		Describe how injur		1 200.00
<u>Ö</u>	ath. rr: Aft	atlo	1 Natural 5 ☐ Pending investigation		ear) Injury		2 □ No			
Division of	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre	et, factory, office	28f. L	ocation (Street an	d Number or Rura	Route Number,
	itel o rs aft el Di led in	Cer		banan gi otor (ity or Town, State	/	
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	ysician: To the best of n niner: On the basis of ex and manner stated	amination and/or invi	occurred at the time, of estigation, in my opinion	date and place, and di on, death occurred at	ue to the cause(s) the time, date and	and manner as sta place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	^		29c. License nu		29d. Dat	e signed (Month, L	Day, Year)
)	11		Mass) 3	9889	MA	nch 28	, 2005
	16		30. Name and address of person who			•				
				MALPHAIL		· ~ MD	21014			
	Sta Registr	.08	31. Date filed (Month, Day, Year) MAR 3	2005 Registrar's	Signature	down !				

/Medi	ian	1. Decedent's Name (First, Middle, La					2. Date of Deat Month	Day Ye	3. Time of Dear
Carrier to		MICHAEL OLW 4a. Facility Name (If not institution, give			4b City Tourn or	Location of Death	3		5:53 F
Exami	ier	UNIVERSITY OF MARY		L CONTER			ITY	PALT	Death NONE
Funeral				(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	Year) 9.	Birthplace (State or For
Director		127 30 3988	1 2 M 2 □ F	64 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan 16	, 1941 N	Country) New York
natural', or items 23a or 28e-f show digal Examinat must be notified at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Lir
-f sho	ŏ	MD Howard	i	Columbia					1 Yes 2
r 28e	rec	10e. Street and Number		COTUIDIA	10f. Zip Code		11	0g. Citizen of Wha	t Country?
23a o Int be	aiD	11409 High Hay D	rive		2104	4		United	•
ems er m	Funeral Director	11. Marital Status	12. Was Decedent B Armed Forces?	ver in U.S. 13.	Was Decedent of Hi	spanic Origin? (Spec n, Mexican, Puerto P	rify Yes or No-		American Indian,
or it	by Fu	1 Never Married 2 Married	1 XYes 2 □ N	0	1 ☐ Yes 2 🖫 No	Specify:	ioan, oto.)	Specify:	Vhite, etc.
tural' al Ex	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:						White
n "na	Completed	(Specify only highest gr	ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of workin-	g l	16b. Kind of Busine Informati	,
E I	E O	Elementary/Secondary (0-12)	College (1-4or 5-	+)	esman			echnolog	
othe vent,	Bec	17. Father's Name (First, Middle, Last)	•		18. Mother's Name			7
arid mental hygiene. is marked other than sumatic event, the Me	70	Adrian Olwell				Margaret	Smith		
r neatin and mental hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event. The Misdical Examinat must be notified at		19a. Informant's Name/Relationship (and Number or Rural			
m 27		Eileen Olwell/Wi	re			y Drive Co			
or of		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐			matory or other place	·		oc. Location - City	·
Department Important: I any injury c once.		 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice 	-	Metro Cr				Catonsvil	
Department of Health important: if item 27 is any injury or other tre once.		Den Colla	=- While	M01044 2	2. Name and Addres	s or Facility Harr Olumbia Pi	y H. Wi ke Elli	.tzke's F .cott Cit	amily FH I
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	ter the mode of dying	g, such as cardiac or	respiratory arre	st,	Approximate Interval Between
/sician		Immediate Cause (Final disease or condition	. HYPOT	ENSION					Onset and Death
ledical i aminer		resulting in death)	Due to (or as a	consequence of):					
	5	Sequentially list conditions,	b. SEPSI	consequence of):					2 WEEK
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the chiral Cause (Disease or injury that initiated events	NOCO		1 ASPA	RGILLIOS	- je / ch	I I An and C C	ST.
ysician and ie burial-transit	Exa	resulting in death) Last	c. Due to (or as a	consequence of):	1100	. NOICO.	1 19	1010/	
hysicia the bu	icai		d						9
ing ph e as t	Physician/Medicai	IF FEMALE:							
attending p	ian/i	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Petal death 3□	Ectopic pregnancy			23d. Date of Month	,
o D → D	ysic	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death 5	Other (specify)			Monut	Day Year
후 문		Part II. Other significant conditions of	contributing to death bu	t not resulting in the u	nderlying cause give	n in Part I	23e. Did toba	acco use contribute	e to the cause of death
ed by the detached	d by		•	,	,,				Probably 4 Unkno
gned be de	വ						24a. Was an		
been signed should be de	et						autopsy perform	ed?prior death	
has been signed je 2 should be de	omplet						1 ☐ Yes 24		es 2 No
ificate has been signed or, page 2 should be de	e Completed	25. Was case referred to modifical		-		26 Place of Death	Chaple anti-		
is certificate has been signed director, page 2 should be de	o Be C	25. Was case referred to medical saminer? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 □ ER/Outpatier	t 3 DOA Othe	26. Place of Death			inacih()
is certificate has been signed director, page 2 should be de	To Be C	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	I S DOA	r: 4 🗆 Nursing Home	5 Resider		pecify)
After this certificate has been signed funeral director, page 2 should be de	To Be C	examiner? 1 Yes 2 No 27. Manner of Peath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury Work	r: 4 🗆 Nursing Home	5 Resider	nce 6 Other (S	pecify)
After this certificate has been signed funeral director, page 2 should be de	To Be C	examiner? 1 Yes 2 No 27. Manner of Death 1 Notural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c, Injury Work' M 1 Y	T 4 ☐ Nursing Home at 28 ? es 2 ☐ No	5 Resider d. Describe hov	oce 6 Other (S	pecify) Rural Route Number,
Director: After this certificate has been signed in by the funeral director, page 2 should be de	Certification; To Be C	examiner? 1	28a. Date of Injury (Month, Day and building, etc.	Year) 28b. Time of Injury ry - At home, farm, str (Specify)	28c. Injury Work M 1 Y eet, factory, office	4 Nursing Home at 28 es 2 No	5 ☐ Resider d. Describe hov f. Location (Stree City or Town,	oce 6 Other (S vinjury occurred set and Number or State)	Rural Route Number,
Funerel Director: After this certificate has been signed ely filled in by the funeral director, page 2 should be de	Certification; To Be C	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not b determined	28a. Date of Injury (Month, Day 28e. Place of Injury building, etc.	y - At home, farm, str (Specify) my knowledge, death	28c. Injury Work: M 1 Y	4 Nursing Home at 28? es 2 No	d. Describe hov	oce 6 Other (S vinjury occurred	Rural Route Number,
is a steel vestor. After this cartificate has been signed titled in by the funeral director, page 2 should be de	ertification; To Be C	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b determined 29a. Certifier (Check only 2 Medical Exam	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	y - At home, farm, str (Specify) my knowledge, death	28c. Injury Work: M 1 Y	at 28 es 2 No 28 e, date and place, an inion, death occurred	5 S Resider d. Describe hov f. Location (Streeting or Town, d due to the cau at the time, dat	oce 6 Other (S vinjury occurred	Rural Route Number, as stated. lue to the cause(s)
Funerel Director: After this certificate has been signed ely filled in by the funeral director, page 2 should be de	edical Certification; To Be C	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b determined 29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	28a. Date of Injury (Month, Day 28e. Place of Injury building, etc.	Year) 28b. Time of Injury y - At home, farm, str. (Specify) my knowledge, death examination and/or insended.	28c. Injury Work: M 1 Yeet, factory, office	at 28 es 2 No 28 e, date and place, an inion, death occurred	5 S Resider d. Describe hov f. Location (Streeting or Town, d due to the cau at the time, dat	nce 6 Other (S w injury occurred set and Number or State)	Rural Route Number, as stated, lue to the cause(s)

Please Type or Print in Black Indelible Ink. Ens	sure All Copies Are Legible.
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G			St. State Unpend Item 23ad	ate of Maryla 27 per me	nd / Depa G842 <u>C</u> 47	rtment of H	ealth and Seath	d Mental Hy	giene	005	12633
			Decedent's Name (First, Middle, Last)				-10	2. Oate of De	21.0	Year	3. Time of Death
	Physici /Medio		Clinton Eugene Olson		_			April		005	21:12 P M
	Examin		4a. Facility Name (If not institution, give street Union Hospital	and number)		4b. City, Town, or E1kton	Location of De	eath		County of Death	
9	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Bi	rth av. Year)	9. Birth	place (State or Foreign ntry)
H	Director		214 39 8611 1XIM	41	Yrs.	Monato Bayo	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				sylvania
)	and	-	Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	cation					10d. Inside City Limits
	the Maryland 28a-f show natified at	ō	Maryland Cecil	F1	kton						1 ☐ Yes 2X☐ No
	28a	Director	10e. Street and Number		KLOII	10f. Zip Code			10g. Citiza	en of What Cou	ntry?
	after death with or Items 23a or	ai D	23 Pinder Avenue			21921			United	d State	s
	items 23	Funerai	A A	as Decedent Ever in med Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? In, Mexican, Pi	(Specify Yes or Nuerto Rican, etc.)	0- 14	 Race - Ameri Black, White 	
36	hours after turel', or ite	by Fu	If	TXYes 2□No 19 Yes, Give ear or Dates: 19	982-	1 ☐ Yes 2 💆 No	Specify:		5	Specify: Wh	ite
5-0036	72 hours 'naturel',	edt	15. Decedent's Education		16a, Dece	ient's Usual Occupa	ation		16b. Kind	d of Business/la	ndustry
215		Completed	(Specify only highest grade continued of the state of the	pleted) ollege (1-4or 5+)		kind of work done of OO NOT use retired		working			
2121	e filed withir il Hygiene. other than vant, Ir e M	Com	12		Concr	ete Fini				tructio	n
nd	2 C 2 2	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle		Sumame)	
Maryland	Mer	7	Nelson Olson 19a. Informant's Name/Relationship (Type, P	rint)	19b. Mailir	ng Address (Street a		Jean Wal		Town, State, Zi	c Code)
Ma	01 00 00 00		Norma Olson/Mother	,				North Eas			
ē,	of Health item 27 other tre		20a. Method of Disposition	20b	Place of Dispo	sition (Name of	!	Date	20c. Loc	ation - City or T	own, State
E O	Page tent o nt: If iry or		14 Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ral from State NC		natory or other place t Method: terv		:i1 6,	North	h Fast l	Maryland
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or otl once.		21. Signature of Funeral Service Cicenses			. Name and Addres		Crouch Fi			
<u> </u>	# Q E # 9		Shill Hell			7 South	Main St	reet,Nor	th Eas	st,Mary	land 21901
п			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the de use on each line.	ath. Do not ent	er the mode of dyin	g, such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	herosclero		rdiovascu	lar Dis	sease			
	Examiner			Due to (or as a cons	equence of):						
		Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):						
	cuted od ransit	Examin	that initiated events								
, 0,	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	cate phys	dicai	d								
9 X	eath certific attending p for use as	0	IF FEMALE: 23c. If	yes, outcome of preg	nancy		· · · · · ·		23	3d. Date of deliv	rery
Box	The law requires that the death certific te has been signed by the attending I tage 2 should be detached for use as	by Physician/M	in the past 12 months?	Live birth 2 Fe		Ectopic pregnancy Other (specify)				Month	Day Year
P.O.	at the de by the a tached	hys	9 Unknown	Unknown							
	es that igned b	by F	Part II. Other significant conditions contribu	ting to death but not re	esulting in the u	nderlying cause give	en in Part I.				the cause of death?
Vital Records,	w require been si should I	Completed						-			
3ec	e law has b	mpi						24a. Was auto perf	opsy ormed?	prior to co death?	opsy findings available ompletion of cause of
al			25. Was case referred to medical				26 Place of	1 ☑ Yes Death (Check only	2 No	XX Yes	2 No
Ξ	Physician: r this certific ral director,	To Be	examiner? 1X Yes 2 No	al: 1 ☐ Inpatient 2	XER/Outpatier	nt 3 DOA Oth	00	ng Home 5 Res		Other (Spec	(fy)
J of	ding Phy h. After thi funeral o		27. Manner of Death 1 ♣Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe	how injury	occurred	
sior	Attending r death. ector: After by the fune	catic	2 Accident investigation			M 1 🗆	Yes 2 □ No		10		
Division	or Att	Certification;	3 Suicide 6 Could not be determined 28	le. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office			(Street and own, State)	Number of Hui	al Route Number,
	Hospital		29a, Certifier 1 ☐ Certifying Physicia	a: To the best of my k	nowledge, deat	h occurred at the tin	ne. date and o	lace, and due to the	e cause(s) a	and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner:	On the basis of exami and manner stated.	nation and/or in	vestigation, in my o	pinion, death o	occurred at the time	, date and p	place, and due	to the cause(s)
_	To the within 2 To the complex	Me	29b. Signature and title of certifier	7		29c. Licens				signed (Month	
				m RIPP	IR FOR	00	CME		Apri	il 3, 20	JU5
	2+1		30. Name and address of person who comple	ted cause of death (It	em 23a) (Type,	Print)	enn Str	eet Balt	imore	. MD 21	201
	Sta	ate	MACLAMITA 31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature .					,	
	Regist		APR 1 2 2005	Alanson 1	S. Apa	فياله					•

	1 - For State Registrar	State of Marylan		artment of H			giene Reg. No.	5 125	34
Physician /Medical	1. Decedent's Name (First, Middle, Last					2. Date of Dea Month March	ath Day	3. Time of 9:25	Death a M
Examiner	4a. Facility Name (If not institution, give Montgomery Hospi	street and number)	e	4b. City, Town, or Rockvil	le	h	4c. County		
Funeral Director	5. Social Security Number 6. Se 220 – 74 – 2779 Usual Residence of Decedent	7. Age (In yrs. 4		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug • 4	, Year) , 1958	9. Birthplace (State of Country) Washington	
within 72 hours after death with the Maryland ene. 19. 19. 19. 19. 19. 19. 19. 1	10a. State 10b. County		y, Town or Lo					10d. Inside Ci 1 ☐ Yes	
h with the Mai 3a or 28e-f s st be notified	10e. Street and Number 4316 Skymist Te	rrace		10f. Zip Code 20832			10g. Citizen of W USA	√hat Country?	
Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28e-f show then treumatic event. Ite Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- o Rican, etc.)	Black	e - American Indian, k, White, etc. White	
Il Hygiana other than "nature rent, Ira Mudical E	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired, emaker	lurina most of wo	rking	16b. Kind of Bu	·	
s merked other umatic event, III	17. Father's Name (First, Middle, Last)		,			me (First, Middle, es David	Maiden Sumame	θ)	
Department of Health and Mental In Importent: If item 27 is marked of any injury or other treumatic even once. To Be	19a. Informant's Name/Relationship (T) Matthew J. Powers 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licens	/ Husband Removal from State Cat	4316 Place of Disponentery, crer te of He	Skymist Skymist Skymist sition (Name of natory or other place aven Cemete L. Name and Address rancis	Terrace, Mar Mar Mar Mar Mar Mar Mar Ma	Olney, Date ch 30, 2005	Marylan 20c. Location	nd 20832 City or Town, State	
physician and ithe burial-transit and meaning the burial-transit and	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Breast Cane Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of):					Interval Bety Onset and D	Peath
led by the attending p detached for use as y Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery nth Day Y	'ear
be d	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
certificate has been s rector, page 2 should Be Completed							med? de	Vere autopsy findings a rior to completion of calleath? Yes 2 No	ivailable luse of
the part of the pa	25. Was case referred to medical examiner? 1 Yes 34 No 27. Manner of Death 1 2Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	^{rc} 4 ☐ Nursing H			er (Specify) Hospi	ce
ed in by the funers Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (S City or Town		er or Rural Route Numb	20 <i>f</i> ,
To the Funeral Completely filled	29a. Certifier 1 A Certifying Phy cone) 1 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, o	ause(s) and man late and place, a	nner as stated. and due to the cause(s)	
To th	29b. Signature and title of certifier	V MI	>	29c. License D356		2	-	(Month, Day, Year) 26, 2005	
>	30. Name and address of person who co		aster 1	Mill Road	, Rockvi	lle, MD	20855		
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture A	ules					

			T ICUSC				Health and M			oie.		
			1 - For State Registrer			ertificate of			g. No.	C	12635	
	Physic	an	1. Decedent's Name (First, Middle, Last		F . A			2. Date of Deat Month		Vasa	3. Time of Death	
	/Medi			illiam P	teite			03	23	O5	4:40 PM	
1	Examir	ier	4e. Facility Name (If not institution, give	street and number)	•		Fimore		4c. County	of Death	ee City	
	Funeral		5. Social Security Number 6. Se		'In yrs. last birthd		If Under 24 Hrs.	8. Date of Birth			,	
	Director		154-14-1231		79 Yrs	Months Days	Hours Min.	MAY 30	19 25	NEW	place (State or Foreign ntry) JERSEY	
	and w		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or	Location						
	Manyli f sho	ō	MD TALB		EAS					1	10d. Inside City Limits XX Yes 2 ☐ No	
	r 28e	rai Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Cour		
	23a o		240 BROOKWOOD AV	Е.		2	21601			SA	.,.	
	er dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 1	3. Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-		e - Americ k, White,	can Indian,	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:	,	Specify:			
9-0	be filed within 72 hours after death with the Maryland tal Hygiene. od other then "naturel", or Items 23a or 28e-1 show od other then "naturel". Fya rifrat must be notified at event, it a Mexilca. Exa rifrat must be notified at	ted	15. Decedent's Edu	cation	16a. De	cedent's Usual Occup	pation			b. Kind of Business/Industry		
218	within 7 ene. then "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(G.	ive kind of work done e. DO NOT use retire	during most of working	g		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	addity	
121	filed w Hygien ther th	Con	12	4		IL ENGINEE			J.S. GO		MENT	
anc	d be fi	Be	17. Father's Name (First, Middle, Last) JOSEPH PFETFER				18. Mother's Name	(First, Middle, M A SPARRI		a)		
Maryland 21215-0036	should be nd Menta marked	2	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	ailing Address (Street	L			State Zin	Codel	
Ĭ,	and 2 alth a 27 is er tra		VIRGINIA W. PFEIF	ER/WIFE				lumber or Rural Route Number, City or Town, State, Zip Code) VE., EASTON, MD 21601				
Baltimore,	of He of He If item or oth		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of Dis	sposition (Name of crematory or other place	ce) Da	ate 2	Oc. Location - (Dity or To	wn, State	
tim	t. Pag tment tant: ijury c		* 4 ☐ Donation 5 ☐ Other (Specify)		ST. JOS	EPH'S CEME	ETERY 3-30-	-2005	CORDOVA	, M/	ARYLAND	
Bal	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury or other traumatic a <u>once.</u>		21. Signature of Funeral Service Licens			FELLOWS, E	SS OF FACILITY IELFENBEIN	& NEWNA	M FUNE	I LAS	HOME PA	
			23a. Part 1. Enter the disease, or complete or boot failured in the complete or boot failured in th	ications that caused th		200 S. HAR	RRISON ST.	EASTON .	MD 216	501	Approximate	
	Physician		Immediate Cause (Final	ie cause on each line		bral He		respiratory arro	o.,		Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a c							24 hours	
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Ć,	execu n and ial-trai	Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):							
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99	ing ph	Medi	IF FEMALE:								Table College	
Вох 6	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of particle 1 ☐ Live birth 2 [Fetal death 3	3 □Ectopic pregnancy	,		23d. Date		.,	
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<u>ر</u>	igned by be deta	by Ph	Part II. Other significant conditions cor	tributing to death but n	ot resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contrib	oute to th	e cause of death?	
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ဝင္ပ	e law re has ber je 2 sho	piet						24a. Was an	24b. W	ere autor	osy findings available inpletion of cause of	
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N N	or Attending Physicien: The tree death. Director: After this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death (
ō	Phys or this oral di	5 To	27. Manner of Death	28a. Date of Injury	2 ER/Outpati	ent 3 DOA Out	er: 4 Nursing Home	e 5 Resider)	
Division of Vital	ttending P death. ctor: After i the funera	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury	/ Worl	k? Yes 2 □ No		anjury doddino	-		
N N	r Atte	Certification;	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Could not be determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State)							or Rural	Route Number,	
	oitel o urs af erel Di										\	
	Hosp 24 ho Fune etely f	Medical	29a. Certifier 1 ✓ Certifying Phys (Check only 2 ☐ Medicel Examir	ician: To the best of m	ny knowledge, de amination and/or	ath occurred at the tim investigation, in my or	ne, date and place, an pinion, death occurred	d due to the cau I at the time, dat	ise(s) and mani e and place, an	ner as sta id due to	ated. the cause(s)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Me	29b. Signature and title of certifier			29c. License	number -	296	d. Date signed	(Month, E	Day, Year)	
)			William Wi	1 Charsh	, MS	Pi	6602		3/2	3/0	5	
			29b. Signature and title of certifier 29b. Name and address of person who co 30. Name and address of person who co 31. Date filed Marth 20am 2005	mpleted cause of death	(Item 23a) (Type	e, Print)	1. 1 2. 1	ical cer	rtea A	141	more ms	
	Stat	0	31. Date filed (Months Day Year)	132 Renistrarie	Signature	ty of Mary	land Inca		1		21201	
	Stat Registra		MAR 2 8 2005	Actor	& Aco							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene... Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year MARION CROCKETT PRUITT 03 30 2005 14:48 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth EDWARD W. MCCREADY Memorial Hospital Crisfield SOMERSET 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 1□M 2ŬF Months Days Hours VIRGINIA Yrs 224-74-2908 94 Director 11/05/1910 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** VIRGINIA 1 Yes 2 □ No ACCOMACK TANGIER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 16691 WEST RIDGE 23440 ROAD 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced Specify: WHITE Year or Dates 15. Decedent's Education
(Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE T. CROCKETT SARAH ELIZABETH (UNKNOWN) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSALIE PRUITT/DAUGHTER 16691 WEST RIDGE RD., P.O. BOX 172, TANGIER, VA 23440 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State NEW TESTAMENT CEMETERY 04/02/05 TANGIER, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name and Address of Facility WILLIAMS FUNERAL HOME 25046 PARKSLEY ROAD, PARKSLEY, VA 23421 of enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that caused the or heart failure. List only one cause on each line death. Do not enter the mode of dying, Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical eumouia Examiner Physician/Medical Examiner ilmonau The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Othar significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2√ No 3 Probably 4 Unknown ۵ certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 2 1 No 1 Tyes 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA After this Certification: 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation after death.

Director: Aft
d in by the fur 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier (Check only one) to Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune completely fi Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month. Dav. Yeer) 18098 30/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

32. Registrar's Signature Slave & Sparke

VIJAY KARUMBUNATHAN, M.D., 201 HALL HIGHWAY, CRISFIELD, MD

			1 - For Stata Registrar		Sta	ate of N	Maryla	nd / Depa <i>Ce</i>	artmen <i>rtificat</i>			and M	lental Hy	giene	'HHI	1263	7		
	Physici	an	Decedent's Nam	e (First, Middle,	, Last)								2. Date of De	aath Day	y Year	3. Time of Dea	ith		
	/Medi	cal	ROBERT CHESTER POWELL										March	27	2005		М		
	Examir	ner	4a. Facility Name (it not institution, undalk l	give street Road	and numbe	r)		4b. City, Take		Location o	of Death			County of Dea				
F	Funeral		5. Social Security N	lumber	6. Sex	7. A	lge (In yrs	. last birthday)	If Under		If Under	24 Hrs.	8. Date of Bi	rth	ntgomer	Y thplace (State or For	reian		
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	deat	ner	11. Marital Status		12. Wa	as Deceden	t Ever in l		Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No		14. Race - Ame	ce - American Indian,			
36	or It	y Fu	1 Never Marr		ed 📉	XYes 2 ☐ /es, Give			1 ☐ Yes		Specify:	, rueno	Rican, etc.)		Black, Whit Specify:	e, etc.			
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Division of	l or Atten after deatl Director: I in by the	ertification;	4 Homicide	determin		building, e	tc. (Special	ome, farm, stre fy)	et, factory,	office		2	8f. Location (S City or Tow	Street and m, State)	Number or Rui	ral Route Number,			
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	To the Hospital or Attenwithin 24 hours after deation to the Funerel Director: completely filled in by the	edical	(Check only one)	2 Medical Ex	taminer: Or	the basis of manner st	or examina	ation and/or inv	estigation,	in my opi	nion, death	occurre	d at the time, o	date and	place, and due	to the cause(s)			
	To the within 2 To the complet	M	29b. Signature and	title of certifier	15	0	Q	1.	29c.	License	number	0	2	29d. Date	signed (Month	Day, Year)			
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2	(6)		30. Name and addre	person wt	no complete	d cause of	death (Iter	m 23a) (Type, F		le,	Rad	11,11	O MI	\ 1	085C				
	Sta	.0	31. Date filed (Mont	h, Day, Year)	1 1	32 Regist	rar's Sinns	ature	111	رب	nuch	V (1)	C/141	J Q	0000				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 25 **EMMA** PACE 7:25PMw **Physician** G. 2005 MARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CROFTON CROFTON CONVALESCENT CENTER ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min | PRIL 28 Birthplace (State or Foreign Country)
 N . C . 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 3^{Year} 1920 **Funeral** 1□ M 2√ F Yrs. 84 579 26 2832 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show traumatic event, the Medical Examiner must be notified at D.C. WASHINGTON 1 XYes 2 No Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 첉 522 20019 46th STREET, S.E. #1 USA or Items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Mudical Examinations. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) ADMINISTRATOR SPECIAL ED. 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CLAUDE GODWIN LULA ONEAL ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOHNETTE J. HOWARD/DAUGHTER 522 46th ST., S.E. #1 WASH. DC. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEM. PARK 3/31/05 LANDOVER MD. `4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Sign yur of Funeral Service Licensee WATSON F . 20010 3435 14th ST., N.W. 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athero Sclerotic Candio Vusculan Distan **Physician** /Medical + heroscleratic Cerebro Vascular Distase Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardio Vascular Distance ed by the attending physician and detached for use as the burial-transit Typentern V.C. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2/2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes al or Attending Physician: After this certification 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier aKush MD 20 108 and 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 GALLANT FOX ARORA , m.D. LANE 31. Date filed (Month, Day, Year) State MAR 2 9 2005 Registrar

			For State Ragistrar		aryland / Dep <i>Ce</i>		Health and	Mental Hyg	•	10000			
			1. Decedent's Name (First, Middle,	Last)				2. Date of Deat	ite of Death 3. Time of Death				
	Physici /Medi		Robert Ells	vorth Redo	ling			Month	h 28 2005 8:12 P				
	Examir		4a. Facility Name (If not institution,			4b. City, Town, o	City, Town, or Location of Death 4c. County of Death						
			Frederick Memor			Freder		Frederick					
	Funeral Director		5. Social Security Number 217-48-3004 Usual Residence of Decedent	S. Sex 7. Age 1 X M 2 ☐ F	6 (In yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			thplace (State or Foreign ountry) cyland			
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits			
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336	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show deat Examinat must be redified at	by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:	10	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2X No		pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit				
Š	2 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Business				
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23a or 28e-f show any injury or other treumatic event, the Marical Examinar must be rediffed at ADRE.		Gladys R. Reddin 20a. Method of Disposition 1 XBurlar 2 Cremation 3 4 Dohation 5 Other (Spe	g - Mother □Removal from State ccity)	2851 20b. Place of Dispo cemetery, crea Lorraine	Flag Ma: osition (Name of matory or other place Park Ceme	rsh Road etery 4	Mount 2 /01/05 Ba	City or Town, State, 2 Airy, Mary Oc. Location - City or altimore, uneral Hom	land 21771 Town, State Maryland			
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Division of Vi	ling Phys After this uneral dii	ToB	examiner? 1	28a. Date of Injury (Month, Day	nt 2 ER/Outpatier y Year) 28b. Time of Injury	28c. Injun Work	er: 4 ☐ Nursing H	th (Check only one) ome 5 Residen 28d. Describe how	ce 6 ☐Other (Spec	ify)			
DIVIS		Certification	3 Suicide 6 Could not 4 Homicide determine		ry - At home, farm, str . (Specify)		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,				
	he Hospital in 24 hours a he Funerel I pletely filled	edical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occur	, and due to the cau rred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)			
	To the within 2. To the Complet	Σ	29b. Signature and title of certifier	Mem M	1.0	29c. License	57796		1. Date signed (Month Much 29				
	9		30. Name and address of person wh		ath (Item 23a) (Type, Vest Seven	•	Eno.d-	riol: Ma	TO Lacky	201			
	Sta Registra	le ar	31. Date filed (Month AR Year)	2005 32. 8 pistrai	r's Signature	En Bereet	rrede	LICK, Mar	Arana 717	VI			

			For Stata Registrar	State of Ma	•		nt of Health te of Death			giene	OOE	12640
			1. Decedent's Name (First, Middle, Li	ast)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		SAMUEL GENE RED	DICK, SR.					Month MARCH	2 5		5 4:15P ^M
	Examir		4a. Fecility Name (If not institution, gi			4b. City	, Town, or Location	of Death			County of Dea	
			SOUTHERN MARYLA	ND HOSPITAI			CLINTON	J		ŀ	PRINCE	GEORGES
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthd	Months		r 24 Hrs.	8. Date of Birt (Month, Day	h v. Year)		thplace (State or Foreign ountry)
	Director		246 72 9080	XX M 2□F	58 Yrs				OCT. 09		946 NO	RTH CAROLINA
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	r Location					_	10d. Inside City Limits
	the Marylar 28e-f show notified at	5			-							XX Yes 2 □ No
	the N	Director	MARYLAND PRINCE (10e. Street and Number	GEORGES	SUITLAN		Code			10- 0:4		
	ours after death with the Maryla rat', or Itams 23a or 28e-f shov Examinat must be notified at	Ξ	Toe. Street and Number			101. 2	ip Code			rog. Citi	zen of What C	ountry?
	sath w	Funeral	4431 RENA ROAD #:		Ever in H.S.	0 W D	20746	-i-i-0 (0			TED STA	
	ltams	ů	11. Marital Status 1 □ Never Married 2XXMarried	12. Was Decedent Armed Forces? 1 ☐ Yes XXI	Ever in o.s.	If Yes, sp	edent of Hispanic Or ecify Cuban, Mexica	an, Puerto R	ican, etc.)		Black, Whi	
36	irs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	XX No Specify	<i>'</i> :			Specify: B	LACK
ò	72 hours after death with the Maryland "netural", or Itams 23a or 28e-f show idical Examinar must be notified at	ed	15. Decedent's E		16a. De	ecedent's Usi	ual Occupation			16b. Ki	nd of Business	/Industry
215-0036	n n	Completed	(Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-4or 5	lif	ive kind of w e. DO NOT	ork done during mo: use retired)	st of working	g			,
212	filed within Hygiene. other than "	Eo	12TH	College (1-401 S		то вор	Y REPAIR				PRIVATI	Ξ
Б	e filed Il Hygid other	Bec	17. Father's Name (First, Middle, Las	t)			18. Moth	er's Name	(First, Middle,			
Maryland	s 1 and 2 should be filed within 72 ho Health and Mental Hygiene, item 27 Is marked other than "netun other traumatic event, the Medical	To E	JAMES LEE BRADLE	Y			CAR	RRIE R	EDDICK			
ary	2 should and Men Is marke		19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Addres	s (Street and Numb	er or Rural	Route Numbe	r, City o	r Town, State,	Zip Code)
	1 and 2 Health tem 27 I		FLORENCE REDDICK	/ WIFE	44	31 REN	IA RD. #3	SUI	TLAND,	MD	20746	
ore.	of He		20a. Method of Disposition	Damaual from State	20b. Place of Di cemetery, of	sposition (Na		Da	ite	20c. Lo	cation - City or	Town, State
altimore,	Pages nent of I		XIX Burial 2 ☐ Cremation 3 [LINCOLN	MEMOR	IAL CEM.	03/31	/2005	SI	ITLAND	MD
att	permit. Pages 1 a Department of Her Importent: If item any injury or otha once.		21. Signature of Funeral Service Lice	ensee		22. Name a	nd Address of Facil	lity				
B	89529		1.7. 77	arshell		4308 S	LL'S FUNE UITLAND R	ROAD			MD 20	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do not				respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cons	est in l	uart	failure	Rt	side			Onset and Death
7	/Medical		resulting in death)	Due to (or as	a consequence of):		fuilure a (spate					unknows
	Examiner		Convention lies conditions	14700	xic on	ceph	a (spate	ing .				unknown
	n ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due te (er as	a consequence of):		,	0				
	cuter	Examin	that initiated events	c								
Ö,	e exe		resulting in death) Last	Due to (or as	a consequence of);							
8760,	death certificate be executed e attending physician and id for use as the burial-transit	edical		d								
9	leath certific attending pl	Med	IF FEMALE:									
Вох	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth		3 □Ectopic p	oregnancy			2	23d. Date of de Month	. ,
	ie dea the at hed fo	SICI	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 Other (s	pecify)				MOHIII	Day Year
P.0	that the d ed by the detached	Physician/M				-			00- 0:44			
ŝ	se un eq	þ	Part II. Other significant conditions	contributing to death bi	ut not resulting in th	e underlying	cause given in Part	1.				the cause of death?
oro	v requir been si should	ted							1 1 7	es 2[1N0 3LIP	Tobably 4 Donknown
Records,	has b	nple							24a. Was a autop	sy	prior to	utopsy findings available completion of cause of
<u> </u>	Ø 11	Completed							1 Yes	med? 2 ⊡ No	death? 1 ☐ Yes	2 2 No
Vital	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					e of Death (Check only o	ne)		
of	di S	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Impatie							Other (Spe	cify)
		on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 28b. Time Inju		28c. Injury at Work?		d. Describe h	ow injury	occurred /	
Sio		cat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not I			М	1 Yes 2					
Division	l or Attene after deatl Director: i in by the	Certification:	4 Homicide determined		ury - At home, farm, c. (Specify)	street, facto	ry, office	28	City or Tow	treet and n, State,	d Number or R	ural Route Number,
	urs a		20.0.4**									
	Hos 14 ho Fun Fun tely f	edica	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination and/o	eath occurred r investigation	d at the time, date ar n, in my opinion, dea	nd place, an ath occurred	id due to the c d at the time, c	ause(s) late and	and manner as place, and due	s stated. a to the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Med	one) 29b. Signature and title of certifier	and manner sta		20	c. License number			29d. Date	a signed (Mont	h. Dav. Yearl
	T ≥ S		Rait I	Frankl	_ M A	-	-	1	•	المان . ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ	3/26/0	*
-71	P		,		- ; \ U	B	D43446	3			-1 2010.	20407
1	(2)		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	oe, Print)	n estada A	P 1815	+21.0	40.0	Jan C	and Hin
	- Ct		31. Date filed (Month, Day, Year)		ar's Signature	-	7	- Jul	-	7-1-3	,,,,,,	7
E	Sta Registr		MAR 2 9 2005	Steen	N. Apri	W.						

DHMH 17 Rev 1/2001

	State of Maryland / Department of Health and M 1- State Registrar Certificate of Death	
Physician	Decedent's Name (First, Middle, Last)	Date of Death Month Day Year
/Medica	KATHOND L. KODINSON SK.	MARCH 23 2005 6:10 PM
Examine	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death DOCTOR'S COMMUNITY HOSPITAL LANHAM	4c. County of Death
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	PRINCE GEORGE'S 8. Date of Birth 9. Birthplace (State or Foreign)
Funeral Director	217-34-0296 18 M 2 F 67 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) WASHINGTON, DC
	Usual Residence of Decedent	MINIE O 1997 WASHINGTON, DC
show	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
the Mi	MD PRINCE GEORGE'S CLINTON	12∑Yes 2 No
with th	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
eath w	8504 WOODYARD ROAD 20735 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	U.S.A. acify Yes or No- 14. Race - American Indian,
after d	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No ARMY	Rican, etc.) Black, White, etc.
5-0036 72 hours aft maturel; or	3 □ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify:	Specify: BLACK
5-00:	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work) (ife. DO NOT use retired)	16b. Kind of Business/Industry
d 21215-0036 filed with the Maryland Hygiene then "naturel", or Items 23e or 28e-1 show out, the Medical Examinationation in the Medical Examination	Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTOR	PRIVATE
(2 y mond) Ry mond Iand 21215-0036 Id be filed within 72 hours after death with the Maryla ental Hygiene ked other then "naturel", or tiems 23e or 28a-f show ic event, the Medical Examination and the profiled at the pro	17. Father's Name (First, Middle, Last) 18. Mother's Name	a (First, Middle, Maiden Sumame)
Maryland Maryland d 2 should be fith th and Mental Hy 27 Is marked oth traumatic even TO BO	ROGER ROBINSON LUCY WR	The state of the s
shared with	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)
	ELAINE M. ROBINSON/WIFE 8504 WOODYARD ROAD CLI	
Robinsen, Baltimore, Noemit. Pages 1 and Jepantiment of Health mocrant: If item 27 and and any anjury or other transe.	1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date 20c. Location - City or Town, State
altim	`4 □Donation 5 □Other (Specify) Maryland Veterans 3/31	
Rettimo Baltimo pentil. Pages Departil. Pages Department of Importants if Importants if any njury or ones.		. B. Jenkins Funeral Home
	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	Landover, Maryland 20785
Physician	shock, or heart failure. List only one cause on each line. Immediate Cause (Final CCCPIRATORY FAILURG	Interval Between Onset and Death
/Medical	Immediate Cause (Final disease or condition resulting in death) A ESPIRATORY FAILURG Due to (or as a consequence of): METASTATIC RENAL CE	THE TRE
Examiner		ELL CANCER 3 WILL
9), executed an and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events	
60, be executed ician and burial-transit	that initiated events resulting in death) Last Due to (or as a consequence of):	
Box 68760, sath certificate be executed attending physician and for use as the burial-transitian/Medical Examin	d	
687 tifficate g phy as the		
Box 6 eath certifications attending for use as	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	23d. Date of delivery
O. B.O. Be death the atterned for hed	in the past 12 months? 1 Yes 2 Other (specify)	Month Day Year
S, P.O. Box es that the death cert igned by the attending be detached for use a by Physician/M	9 Unknown	222 Sid tabasas and state to the state of th
		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes ② 200 0 3 ☐ Probably 4 ☐ Unknown
Cord w requir		7
al Record The law requir cate has been signage 2 should		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital F iician: Th certificate rector, pag		1 Yes 2 No
of Vi hysicia his cer il direct	examiner? 1 Yes 2 Other: 4 Nursing Hon	ne 5 Residence 6 Other (Specify)
on of Vital Reding Physician: The h. After this certificate he funeral director, page		28d. Describe how injury occurred
isio ittendii death. ctor: A / the fu	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Injury. At home farm street factors (figure 4)	
Division ce tall or Attending Person after death. el Director: After ed in by the funers	3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
spital Cours 2	29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the course(s) and manner as stated
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and at the time, date and place, and due to the cause(s)
To th withir To th comp	29b. Signature and title of certifier 1/1	29d. Date signed (Month, Day, Year)
	D 28195	05-24-2005
00 /10)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A GOTHY, MD, 1450 MERCANTILE LA	#217 LARGO MD 26776L
		., -, -, -, -, -, -, -, -, -, -, -, -, -,
State Registrar	31. Date filed (Month, Day, Year) MAR 2 9 2005 MAR 2 9 2005	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Benton Reams 26 March 2005 8:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 217 Wardour Drive Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 415-18-2211 M 2□F 79 Director Vre July 2, 1925 Tennessee Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic avent, Tro McJical Examination ust be notified at 10d. Inside City Limits Director 1 TyYes 2 □ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? filed within 72 hours after death with 217 Wardour Drive 21401 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Affiled Forces: 1. Eyes 2 □ No If Yes, Give Year or Dates: 1947–1966 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic avent, I'm Mode once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Naval Officer Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Chatham C. Reams Avaligne Edgington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 217 Wardour Drive Annapolis, MD 21401 Nancy Reams/wife

20a. Method of Disposition

1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ^¹ 4 □ Donation 5 □ Other (Specify) Baltimore Crematory 3-29-05 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc cott 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician discase Artes Due to (or as a consequence of): 4-5 /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): o the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: dir 2 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After I Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death | Director: , d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours at the Funeral D npletely filled in 29a. Certifier 🗠 👉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the complet 29c. License number 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) 14415 (IM ci). suite 241 egistrar's Signature State 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Day 2005 Month **Physician** March 23, Joseph Skinner 7:00am /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Heartland Nursing Home Adelphi Prince Georges If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) October 10, 1941 Washington, DC 5. Social Security Number **Funeral** Devs Hours 1⊠M 2□ F Yrs. 577-56-8942 63 Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If them 27 is marked other than "naturel", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits mat be notified at MD Prince Georges 1X Yes 2 □ No Landover Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1945 Dutch Village Drive 20785 U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 1 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 10th U.S.A. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Peter Skinner 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 20b. Place of Disposition (Name of cametery, crematory or other place)

Landover, Maryland 20785

Date 20c. Location - City or Town, State other t Vivian Skinner/Wife 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State ō Department in 3/28/05 Riverdale, Maryland Riverdale Crematory 4 ☐ Donation 5 ☐ Other (Specify) injury 22. Name and Address of Fecility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Pent. Enter the disease or complications that caucal the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner LUNS infections Physician/Medical Examine or Attanding Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? erebral anoxia with 1 Yes 28JNo 1 ☐ Yes 2€XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28c. Injury et Work? 27. Menn of Deeth 28b. Time of 28d. Describe how injury occurred Injury 1 Naturel 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 0W(2 11 A5 ton 31. Dete filed (Month, Day, Year) . Registrer's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

				otato of ma	(Certifica	ate of		R	eg. No. 0)5	12544	
	Physici	an	1. Decedent's Name (First, Middle, I	ast)					2. Date of Deet Month	h Day	Year	3. Time of Death	
4	/Medic		Gregory C.			Mar.	23 20	005	11:42 P.M.				
	Examin	er	4a Fecility Neme (If not institution, g		4b. City, Town, or Location of Deeth 4c. County of Death								
			5. Social Security Number 6.		(In yrs. lest birth	doub If Und	der 1 Year	Cambridg If Under 24 Hrs.	8. Date of Birth	Dor	chest		
	Funeral Director		220-52-0482 Usuel Residence of Decedent	10 M 2□F 54	V	Month			(Month, Dey,		9. Birthp Court	place (Stete or Foreign htry) Land	
	lend w	1	10e. Stete 10b. County 10c. City, Town or Location								1	0d. Inside City Limits	
	the Maryler 28a-f ehow notified at	ţ	Maryland Dor	chaster	Cam	bridge	2					1☐Yes 2☐ No	
	or 28s	5	10e. Street end Number	chaseer	- Guii		Zip Code		11	Og. Citizen of	Whet Cour	ntry?	
	th wil	a	413 Boundary A	Je.			21613	513 USA					
	r daa	Funeral Director	11. Maritel Stetus	12. Wes Decedent Ev Armyed Forces?	er in U,S.			Hispenic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Rad	ce - Americ		
Maryland 21215-0036	d 2 should be filed within 72 hours after daath with the Marylend h and Mental Hygiene. I am maturel, or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 💢 Merried 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Yeer or Dates:			2[X No		o r noun, etc.)	Specif	₩:	ack	
5-0	72 hc	Be Completed	15. Decedent's l (Specify only highest g	Education	16e. D	ecedent's Us	sual Occup	petion during most of wor	kina	16b. Kind of B			
21	within ene. then	후	Elementary/Secondary (0-12)		College (1-4or 5+)		work done during most of working use retired)						
2	filed with Hygiene. other than	3	12			Press	sman	1		Cev			
anc	12 should be filed v h and Mental Hygie i is marked other t traumatic event, m	B	17. Father's Neme (First, Middle, Las						ne (First, Middle, M	faiden Suman	10)		
Ž	hould d Me merke	ဥ	Walter S 19a. Informant's Name/Relationship	tanley	105.4	4-11 A -l-l-	(Ct	Minery end Number or Ru		Jnk.			
Ma	id 2 s Ith an 17 ie : trau	- Î	Rebecca Stanl										
	of Haalth item 27 i	ŀ	20a. Method of Disposition	ey / wile	20b. Place of D	isposition (A	lame of	y Ave.,Ca		Mary La:			
9	at: If i		1 Burial 2 ☐ Cremation 3 4 ☐ Denation 5 ☐ Other (Spec		Marylan	crematory o		1	04-01-05	171	1- M	la min'ila mal	
Baltimore,	permit. Peges Department of t important: if its any injury or of	d	21. Signature of Juneral Service Lice	2	Maryran	22. Name	end Addre	ss of Facility	PERCONCENSION	nuri	JCK, FI	aryland	
œ	Depa impo any i	1	1 Duel-	tal				ith Fune:		M1	1 01	1601	
		\dashv	23a. Part1. Enter the diseese, or cor shock, or heart failure. List only	nplications that caused th	e death. Do not	enter the m	ode of dyir	er Street	or respiratory arre	Maryla st,	na ZI	Approximate	
	Physician		Shook, of heart failure. List offi		1.				•		1	Interval Between Onset and Death	
4	/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth) a Puculatic Cavcumy 146										
		ner	resulting in deeth)	Du	ue to (or as a co		_		<u> </u>			9000	
	ortificate be axecuted ing physician and es the bunal-trensit	Examiner	Sequentially list conditions,	Du Du	e to (or as e cor	sequence o	f):			-			
68760,	certificate be axecu rding physician and use es the bunal-tre	ᇤ	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	C							1		
687	ficate phys s the	듛	that initieted events resulting in death) Last	Du	e to (or as e con	sequence of):						
Box		∑ I		d									
	daath ce le attendi ed for use	<u> </u>	Pert II. Other significant conditions	contributing to death but r	not resulting in th	e undertving	Cellse div	ren in Pert I	23h Did tol	19000 1180 000	ntribute to	the cause of death?	
P.O.	w requiras thet tha da been signed by the a should be detached	Completed by Physician/	•		iot rooding in t	io undonying	, souso g,v	GITTI CICL	1 □ Ye			bably 4 Unknown	
Records,	requiras thet een signed b hould be det	g g							24a. Was en	autopsy	24b. We	ere autopsy findings	
00	law red as bee	Set .							perform	ed?	con	ellable prior to npletion of cause death?	
R	The law ata has page 2	E							1 □ Yes	2 10 No		Yes 2□ No	
of Vital	ysician: The li is cartificata ha director, page		25. Was cese referred to medical					26. Piece of Dear	th (Check only one			7100 2210	
>	Physician: this cartific rel director,	9	exeminer? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpe	etient 3 🗆 🗈	OOA Oth	ne:	ome 5 Resider		er (Specify	,)	
0	ng Ph fter th inerel		27. Mann of Death 1 Netural 5 ☐ Pending	28a. Dete of Injury (Month, Day Y	eer) 28b. Tim		28c. Injur Wor	y et k?	28d. Describe how	v injury occurr	ed		
sio	Attending or death. ector: After by the fune	Cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not to			М		Yes 2 □ No					
Division	or Att	Certification:	4 Homicide determined		- At home, ferm Specify)	, street, facto	ry, office		28f. Location (Streetly or Town,	et and Numb State)	er or Rurel	Route Number,	
	pitai ours a mai [ဒ္ဓ	29a. Certifier 1 Certifying Pl	walden Talka hashafa	les suits els s	th	al a 4 4 5 a 4' .						
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one)	nysician: To the best of m miner: On the basis of ex and manner stated	amination and/o	r investigatio	o at the tin	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and ma te and place, a	nner as sta and due to	ated. the cause(s)	
	To th To th comp		29b. Signature and title of certific			2:	9c. Licens	e number	29	d. Date algned	1 (Month, E	Jay, Year)	
			NOKE	VY			リグ	1881		3/2	8/0	٠ ٢	
		:	30. Name end eddress of person who	completed cause of deet	h (Item 23a) (Ty	pe, Print)				-	*		
			Dr. David Sm			Drive,	Suit	e# 5, Car	lton Sta	tion, l	Easto	n,Md.21601	
	State Registra	_	31. Dete filed (Month, Day, Year)	2005 32. Regionar's	Signeture	Bar	10						

DHMH 16 Rev 6/95

ORIGINAL

			1 - For State Registrer	State of N	Maryland / Dep <i>Ce</i>	artment of Hea		ntal Hygien	2005	12645
	Physici	an	Decedent's Name (First, Middle, L The ANSE A		T 7 NID			Date of Death Month D	ay Year	3. Time of Death
	/Medi Examir	cal	TANYA 4a. Facility Name (If not institution, go	STRICK		4b. City, Town, or Loc			.7, 2005	11:34FM
	Exami	iei	Prince Geo				erly		RINCE G	EORGES
	Funeral	П		Sex 7. / 1 ☐ M 2X F	Age (In yrs. last birthday)		Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea	r) 9. Birthp	lace (State or Foreign
	Director		579-68-8844 Usual Residence of Decedent		53 Yrs.			y 19,1	951 Was	h. DC
	ryland how		10a. State 10b. County		10c. City, Town or L				1	0d. Inside City Limits
	he Ma 8a-f s	ecto		ce Geo.		Beltsville	e 			1 XYes 2 No
	with t	Funeral Director	10e. Street and Number 10619 Hock	berrv W	av	10f. Zip Code 2070	0.5	10g. C	Citizen of What Coun	•
	death	nera	11. Marital Status	12. Was Deceder Armed Forces		Was Decedent of Hispa If Yes, specify Cuban, N		Yes or No-	14. Race - Americ	an Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-1 show i.a Modical Extrating transite notilling at	by Fu	1 Never Married 2 Married XXWidowed 4 Divorced	1 XYes 2 If Yes, Give	No CO CO	1 ☐ Yes 2½ No S		an, etc.)	Black, White, Specify: B1	etc. .ack
21215-0036	2 hour	led b	15. Decedent's 8	Year or Dates Education	16a, Dece	dent's Usual Occupation	n	16b.	Kind of Business/Inc	
215	d within 72 piene. r than "m	Completed	(Specify only highest g. Elementary/Secondary (0-12)	rade completed) College (1-4o	(Give	kind of work done during DO NOT use retired)	ng most of working		Capital	Tech
121	70 75 -		17 Este de Norre (First Middle Los	2 yrs		lient Spec			Info Ser	vices
anc	d d d	To Be	17. Father's Name (First, Middle, Las			18.	Mother's Name (F. الم	irst, Middle, Maide .ma Smit	,	
Maryland	2 should be and Mental Is marked o	⊢	19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street and	Number or Rural Re	oute Number, City	or Town, State, Zip	
	그 2 를 달		Chanta B. Pr	octor (I		519 Hockbe				
Baltimore,	permit. Pages t a Department of Hee Important: If item any injury or otha		20a. Method of Disposition 1 ☑ Burral 2 ☐ Cremation 3			osition (Name of matory or other place) a Mem Par]	Date		Location - City or To	
altir	Darting Points		* 4 □ Donation 5 □ Other (Spec 21. Signature/of Funeral Service In-			2. Name and Address of			Columbia neral Ho	
ä	permit Depar Impor any in		Dearge	Aure		246 N. Was				
Ю			23a. Part1. Enter the disease, or cor shock, or heart failule. List only	nplications that cause y one cause on each	ed the death. Do not en line.	ter the mode of dying, su	uch as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)		ary Arter	y Disease				Onset and Death
	Examiner				as a consequence of): ic Hypert	ensive Ca	rdiovas	cular D	isease	Years
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of):	chorve ou	.Lalovab	ourur b	Ibeabe	10415
	s be executed sicien end burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or a	as a consequence of):					
8760,	the death certificate be executed y the attending physicien end iched for use as the buriat-transit	dicai E	(d						
9	artifical ing phy e as th	Medi	IF FEMALE:	~						
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of deliver	y Day Year
P.O.	that the de ed by the detached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		Other (specify)				
	98	by Physician/Me	Part II. Other significant conditions			nderlying cause given in	Part I.	23e. Did tobacco	use contribute to the	e cause of death?
ord	w require been sly should b	eted	Chronic Lym	_	ancer)			1 ☐ Yes 2	No 3☐ Proba	ibly 4 🗷 Unknown
Vital Records,	e la has	Completed	Diabetes Me	llitus				24a. Was an autopsy performed?	24b. Were autop prior to com death?	sy findings available ipletion of cause of
tal		Be Co	25. Was case referred to medical	T		26	Place of Death (C)	1 ☐ Yes 2 🔀 N		2 No
	8 5	ToB	examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inpat		Other			6 ☐Other (Specify)	
o uc	Jing After fune	ion:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time o lnjury	Work?		Describe how inju	iry occurred	
Division of	Attending r death. sctor: After y the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Ir	njury - At home, farm, str	M 1 ☐ Yes		Location (Street a	nd Number or Rural	Route Number.
Ö	of the Clin	Cert	4 Homicide determined	building, e	etc. (Specify)			City or Town, Stat	9)	
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	edicai	29a. Certifier 1∑ Certifying P (Check only one) 1 ☐ Certifying P 2 ☐ Medicel Exa	hysician: To the bes miner: On the basis and manner s	st of my knowledge, death of examination and/or in	n occurred at the time, divestigation, in my opinion	late and place, and n, death occurred a	due to the cause(s t the time, date an	s) and manner as sta d place, and due to	ited. the cause(s)
	To the within to the comple	Mec	29b. Signature and title of certifier	and manners	Stateu.	29c. License nur	mber	29d. Da	ate signed (Month, D	ay, Year)
)			Albert	ERelle.	M.D.	D0007	967	М	ar. 28,	1005
	5		30. Name and address of person who			,	Don't UD	L 5.7 1	i marka	MD 20744
	Sta	te	Albert E. R 31. Date filed (Month Pay, Year)	olle, M. 2005 ³² Megisi		iverbend	Koad, F	t. wash	ington,	MD 20744
	Registr	7	MAK 29	2003	was St of	Jan Shar				

		1 - For State Registrar	State of Maryland	d / Depa		Health and M	Mental Hyg	-) 5	12646
Physici	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month MARCH	h Day 25	2005	3. Time of Death
/Medic Examir	cal	ELIZABETH M. SCH 4a. Fecility Name (If not institution, give s 3632 KAREN CIRCLI	treet and number)			or Location of Death	1	4c. Coun	2005 ity of Death	7:40PM M ER
Funeral Director		5. Social Security Number 6. Sex	м Ж □ F 85	ast birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day, JUNE 14	Year) 1919	9. Birthp Coun MARY	lace (State or Foreign try) LAND
Maryland a-f show	tor	10a. State 10b. County MD DORCHE	,	Town or Lo	ocation VKWOOD				1	0d. Inside City Limits 1 X Yes 2 ☐ No
with the	Dire	10e. Street and Number 3632 KAREN CIRCL	r		10f. Zip Code	21835	11	0g. Citizen o		itry?
ine, intally latter ZIZIO-000 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinational be notified at	by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1 [Yes 2 X No If Yes, Give Year or Dates:			Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Ra	USA ace - Americ lack, White, cify: WHI	etc.
thin 72 hours an "natura	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Dece (Give life.	dent's Usual Occ kind of work don DO NOT use retii	upation e during most of wor red)	king	16b. Kind <i>o</i> f	Business/Ind	dustry
d I L Z I	Be	8 17. Father's Name (First, Middle, Last) JOHN GOTT	0	NI	JRSES AI		ne (First, Middle, M		TH CAR	RE
and Men Is marke	J.	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ng Address (Stree	et and Number or Ru		City or Tow	n, State, Zip	Code)
of Health of Health filtem 27		JAMES A. FAULKNER 20a. Method of Disposition W Burial 2 Cremation 3 DR	20b. P!	ace of Dispo	KAREN C esition (Name of matory or other p	IRCLE, LIN		D 218		wn, State
Daltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		`4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	JR.	FF	CEMETE	ress of Facility HELFENBEIN	V & NEWNA	M-FUNI	ERAL H	RYLAND OME PA
Physician		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Finat disease or condition resulting in death)		. Do not ent	er the mode of d	KRISON ST ying, such as cardiac	EASTON, or respiratory arre	MD 216	501	Approximate Interval Between Onset and Death
Medical Ite be executed avsician and be be be executed in a burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	NIA anda of).						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3]Ectopic pregnar] Other (specify)	ncy			Date of delive	ory Day Year
w requires that been signed b should be deta	by Р	Part II. Other significant conditions con	100	_	nderlying cause o	given in Part I.		acco use co		ne cause of death?
The law recate has been page 2 sho	Completed	J	<u> </u>				24a. Was al autops perform 1 ☐ Yes 2	y	prior to cor death?	psy findings available inpletion of cause of
sician:] s certifical irector, p	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 I	ER/Outnation	nt 3 DOA)ther	th (Check only only one Market)		ther (Specifi	41
tending Phy leath. tor: After this		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. In		28d. Describe ho			0
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, offic	9	28f. Location (Sti City or Town		nber or Rura	l Route Number,
To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical (ician: To the best of my knower: On the basis of examinat and manner stated.							
To the within To the	Me	29b. Signature and title of certifier	MAN	10	29c. Lice	nse number	29	Date sign	ned (Month,	Day, Year)
(5)		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print) 5	03 Byn	St. Ca	mbrid	ge, n	1021613
Sta Registi		31. Date filed (Month Day Year) 20		ure	land .					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per inf 8842 4-14-05 vt.

		Amend 1 - For State Registrar	State of Man		artment of F		Mental Hy	giene Reg. No.	h wh re-	I 6 6 1
Phys	sician	Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	edical miner	Evelyn E. Steele 4a. Facility Name (If not institution, give 2625 Arthur Ave	street and number)		4b. City, Town, o		03		2005 unty of Death rro1	12:20 P ^M
Funei Direct		579-09-2053	JM SIXE	n yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 H		th ay, Year) 1918	Cour	place (State or Foreign ntry) nington, DC
Maryland -f show	tor	Usuel Residence of Decedent 10a. State 10b. County MD Carro1		Oc. City, Town or Lo					1	0d. Inside City Limits 1X Yes 2 □ No
h with the 23e or 28e	al Director	10e. Street and Number 2625 Arthur Ave			10f. Zip Code 21784				of What Cour	
Maryland 21215-0036 6.2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. The marked other then "neturel", or items 23e or 28e-1 show treumatic event, the Medical Event of marken colling	ted by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edit		16a, Dece	Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2 No dent's Usual Occup	Specify:	erto Rican, etc.)	Sp	Race - Americ Black, White, ecify: Whit	etc. Ce
Z1Z13 d within 7: giene. or then "or	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. Homen	kind of work done DO NOT use retired naker	during most of w	vorking	Own	Home	
/land uld be file Mental Hy rked othe	To Be C	17. Father's Name (First, Middle, Last)	enemann				ame (First, Middle Duis Jouy		mame)	
4 2 F G		19a. Informant's Name/Relationship (Todary D. Clark - Solo) 20a. Method of Disposition	on	4071 20b. Place of Dispo	ng Address (Street Louisvil position (Name of matory or other place	le Rd l	Rural Route Numb Finksbur Date	, MD		
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item;	once.	1 → Burial 2 □ Cremation 3 □ 1 → 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Services icons		2:	Memorial Name and Addre Nes-Rina New	ss of Facility	30/2005		ille,	
The law requires that the death certificate be executed THE law requires that the death certificate be executed THE LAW IN THE LAW I	al raminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ilications that caused the ne cause on each line. a. Coronary Due to (or as a c) Due to (or as a c) C. Due to (or as a c) Due to (or as a c)	Artery D onsequence of):	,	ig, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
the death certific by the attending practice as	lan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of particles of the second of the se	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d	Date of delive	ery Day Year
Records, P. he law requires that to the law been signed by ge 2 should be deta	à	arm of the control of		-		en in Part I.				ne cause of death?
	Somp						24a. Was auto perfo		4b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings available mpletion of cause of 2 No
f VITAL F ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ot 30 DOA Oth		eath (Check only			
ISION Of tending Physicath. Stor: After this of the funeral di		27. Manner of Death 1 X Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time o lnjury	f 28c. Injur	4 🗀 Nursing	Home 5 Resi			/)
> 4 - 6 6	` E	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, sti Specify)			28f. Location (City or To		umber or Rura	d Route Number,
Di To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical (rsician: To the best of n iner: On the basis of ex and manner stated	amination and/or in						
To the To the Company	¥	29b. Signature and title of Partifier	lein (29c. Licens				gned (Month, 3/2005	Day, Year)
4		30. Name and address of person who c Chaitanya Ravi, M			Print)	102.5	21133	55/20	-, -000	
	State	31. Date filed (Month, Day, Year)	32. Sigistrar's	0.	barle	,			-	

			1 - For Stete Registrer	State of Maryl		artment of I rtificate of			Reg. No.	05	12648
Н	Physici	an	Decedent's Name (First, Middle, Las	_				2. Date of Do	Day	Year	3. Time of Death
	/Medi	al		Snyder		1		March			4:30 PM M
	Examir	er	4a. Facility Name (If not institution, give				or Location of Death	1		nty of Death	
			Suburban Hosp 5. Social Security Number 6. Se		rs. last birthday)		thesda	8. Date of Bi		ontgon	
r	Funeral Director		212.22.1031	□M 2ÅF 79		Months Days	Hours Min.	Feb. 20	ay, Year)	Cou Mores	place (State or Foreign Intry)
			Usual Residence of Decedent	/ .	,		<u> </u>	reb.zu	1,1720	Mary	land
	ylanc now		10a. State 10b. County		City, Town or Lo						10d. Inside City Limits
	a-fa	ior	MD Montgon	nery	Bethesd	.a					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	ntry?
	23a		10250 Westlake I	Prive #208		208	17		U.S	S.A.	
	r dez	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	0- 14. R	lace - Amen	
36	s afte , or li	by Fu	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 ☐XNo	Specify:	, , , , , ,	Spec		Thite
Ö	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ahow deal Exertites invitted at	D D	3 Widowed 4 XDivorced	Year or Dates:	10.0						
1 5	n 72 "na "na	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worl d)	king	16b. Kind of	Business/Ir	ndustry
7	within iene.	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)		ccountant			Accor	ınting	
Maryland 21215-0036	filed Hygi othar ant.		17. Father's Name (First, Middle, Last)			ccountain	18. Mother's Nam	ne (First, Middle			
<u>a</u>	lid be lental kad ic av	To Be	Watson Sa	abesky			Ka	therine	Stepha	anas	
ary	s 1 and 2 should be filed within 72 ho of Health and Mental Hygiene, itam 27 is markad othar than "natur other traumatic avant, the M. distal		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailin	ng Address (Street	and Number or Rui	ral Route Numb	er, City or Tow	m, State, Zij	o Code)
	and 2 ealth a n 27 is		Eric J. Snyder/ S	Son	324	East 6th	Street A	pt.7 N	ew York	c, NY	10003
re	of He		20a. Method of Disposition	208	o. Place of Dispo	sition (Name of matory or other place	ce) I	Date	20c. Location	n - City or T	own, State
Baltimore,	Page nent on Try or		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,	Tionioval from Otate			atory Mar	ch 26 2	005 414	vandr	of a VA
alti	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Fun ral Service Licens	S88 /	22	2. Name and Addre	ss of Facility Jo	seph Ga	wler's	Sons,	Inc.
m	89 = 8		Alon!	Dos	5	130 Wisco	onsin Ave	nue NW	WDC 20	0016	
	Pnysician /Medical Examiner	er	23a. Part1, Enter the disease, or comp shock, or heart failure. List only of the composition of the composition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):						Interval Between Onset and Death 1 week
68760,	ificate be executed g physician and as the buriat-transit	edical Examiner	cause. Enter Underlying Cause Unisease or kynny that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):						
O. Box	that the death certific ed by the attending p detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	,			Date of deliver	ery Day Year
rds, P.	es De pe	by	Part II. Other significant conditions co Atrial Fibrillati		resulting in the u	nderlying cause giv	en in Part I.				he cause of death?
00		Completed	Bilateral Pneumot	horax				24a. Was	an 24t	. Were auto	ppsy findings available
Re	The law ate has b page 2 s	mo	Diabetes						ormed?	death?	mpletion of cause of
ta		0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	20 No	1 🗆 Yes	2L No
of Vital Record	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 X Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth				ther (Specif	(v)
ion o	i or Attanding Physician: after death. Director: After this certific i in by the funeral director.	atlon: T	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year,	28b. Time of	28c. Injur Wor		28d. Describe			,
Division	tal or Atters as after de al Directo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (City or To	Street and Num wn, State)	nber or Rura	al Route Number,
	To tha Hospital or At within 24 hours after d To tha Funaral Direct completely filled in by	edical	one)	rsicien: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	estigation, in my o	pinion, death occur	and due to the red at the time,	date and place	a, and due to	the cause(s)
)	To I To I	Σ	29b. Signature and title of certifier	- MD		29c. Licens	00060117		29d. Date sign		
	4		30. Name and address of person who con Eric J. Park, M.	D. 9901 Med	ical Ce	nter Driv	e Rockvil	lle, MD	20850		
	Sta Registr	te ar	31. Date filed (Marth Cay, Year) 9 2	005 32. egistrar's Sig	mature.	raile					

		•	For Stata Registrar	State of Marylan		rtment of Heal tificate of Dea		ntal Hygie Reg	6000	12649
			1. Decedent's Name (First, Middle, Last)				2	Date of Death		3. Time of Death
	Physicia /Medic		CHRISTOPHER JOS		LAND			IARCH	25 2005	2:12P M
/	Examin		4a. Facility Name (If not institution, give si NATIONAL INSTITU		LTH	4b. City, Town, or Loca BETHESDA			4c. County of Death MONTGOM	
	Funeral Director		5. Social Security Number 6. Sex 12 12 12 12 12 12 12 12 12 12 12 12 12	7. Age (<i>in yrs</i> . 55	last birthday) Yrs.		nurs Min	Date of Birth (Month, Day, Yop (Month, 11)	ear) Cou	place (State or Foreign ntry) fornia
	pun *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	20	CO Jefferson		vergree					1⊠Yes 2□No
	r 28a-	Director	10e. Street and Number	E	vergree	10f. Zip Code		10g	. Citizen of What Cou	ntry?
	death with the Maryland ms 23e or 28e-f show runst be notified at	ai D	30821 Club House L	ane		80439			USA	
30	d within 72 hours after death with the Marylan jens, rithen "natural", or Items 23e or 28e-1 show the Marical Exercises must be notified at	by Funerai	11. Marital Status 1 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:	1	Vas Decedent of Hispan Yes, specify Cuban, Me ☐ Yes 2 1 No Sp	nic Origin? (Specif exican, Puerto Ric pecify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
9500-61212	2 hou		15. Decedent's Educ	eation	16a. Deced	ent's Usual Occupation kind of work done during	a most of working	16	b. Kind of Business/Ir	dustry
25	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)				
	filed within Hygiene. other than rent, the M		47 Esthada Nama (First Middle Loot)	4 yrs.	Marke	ting Specia	alist Mother's Name (i		Aspen Mark	eting
yland	0 0 0	Be	17. Father's Name (First, Middle, Last) Robert Sutherland				Mary Bry		iden Sumame)	
	should be nd Mental n marked imatic ev	ဥ	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street and N			City or Town, State, Zi,	o Code)
Zar	2 a d		Arlene Sutherland		1	Club House				
Baltimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rt 1 ☐ Donation 5 ☐ Other (Specify)	Billoval Irolli State	Place of Disponentery, crentum tropoli	sition (Name of natory or other place) tan	3-28-0		c. Location - City or T exandria,	
<u>=</u>	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service License		22	. Name and Address of	Facility MArs	hall's E	Funeral Ho	ne
ñ	20 1 2 3		Da Marsh	all		17 9th. St.				
j 1	Physician		23a. Part Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.	th. Do not ente	er the mode of dying, su	ALC:	espiratory arrest		Approximate Interval Between Onset and Death Week
	/Medical Examiner		resulting in death)	Due to (or as a conseq	(uence of):					5 whosers
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	ruence of):	indel o wat			-	, 33
Ď,	cate be executed physician and the burial-transit	i Examin	Sequentially list conditions, if any, leading to in modiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a onseq	uence of):	n Hot	diseas	<u>e</u>	-	6 years
09/8	sate ohy:	dicai	d	-						
J. Box 6	The law requires that the death certifit ite has been signed by the attending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
s, P.O	res that the de signed by the a be detached t	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	nderlying cause given in	Part I.		cco use contribute to	.,
Ö	w require been si should I	eted						24a. Was an		. ^
Vital Records,	The law ite has bage 2 s	Completed						autopsy	prior to co	opsy findings available impletion of cause of
II	ding Physician: The h. h. After this certificate ha funeral director, page	Bec	25. Was case referred to medical examiner?			-	Place of Death (Check only one)		
<u>o</u>	hysic this co	မှ	1 ☐ Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatien			5 Residence d. Describe how	ce 6 Other (Speci	(y)
50	ding P. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes		u. Describe 110#	injury occurred	
Division	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory, office	28	f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filted in by	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Exeminate	sician: To the best of my kno nar: On the basis of examina and manner stated.	owledge, death ation and/or inv	n occurred at the time, divestigation, in my opinion	ate and place, an n, death occurred	d due to the caus at the time, date	se(s) and manner as a and place, and due	stated. o the cause(s)
	Fo the	Me	29b. Signature and title of certifier	Λ Λ		29c. License nur			. Date signed (Month,	
•			Shenhon	olhe		CT 0	42378	m	Mrch 26,	2005
	(5)		30. Name and address of person who column SHENHONG WU	moleted cause of death (iter		Print) ENTER DRIV	VE. BET	HESDA	MARYLAN	20802
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 9 2005	32. Registrar's Signa			_, 251		THAIL	

Andine	n	Decedent's Name (First, Middle, La Frances	Naomi	S	weet		2. Date of Deal Month March 2)5 Year	3. Time of Death 7:30 A.
ledica amine		4a. Facility Name (If not institution, giv 6806 Amelano Dri			4b. City, Town, o	or Location of Deat	h		nty of Death	
eral ctor	- 1	238-46-4051		(In yrs. last birthda 68 Yrs.	Months Days	If Under 24 Hrs Hours Min.		^Y 1936	9. Birthi Nort	place (State or Forei otry) Carolin
fledat	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Freder		10c. City, Town or						10d. Inside City Limi 1 ☐ Yes 2 🛣
t be not	Il Director	10e. Street and Number 6806 Amelano Driv	<i>r</i> e		10f. Zip Code 21702		1	0g. Citizen d US A		ntry?
4	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Morried	12. Was Decedent Ev. Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 13	Was Decedent of H If Yes, specify Cub		pecify Yes or No- to Rican, etc.)		lace - Ameri lack, White, cify:	
alical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5+)	(Gin	edent's Usual Occup re kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of	Business/In	ndustry
aumatic event, tre M		12 17. Father's Name (First, Middle, Last		<u> </u>	Accou		me (First, Middle, I			Storage
ific eve	To Be	Albert	Nix			Sally	, , , , , , , , , , , , , , , , , , , ,	Ho11	,	
trauma		19a. Informant's Name/Relationship (ling Address (Street 5 Jerusal					
any injury or other trai		Charlene Lyles/Da 20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Dis	position (Name of ematory or other pla	(ce)	Date	20c. Location	n - City or To	own, State
njury o		*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	ity)		Cemetery 22. Name and Addre	45		Pooles		
any ir	1	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	ulle Cli	ine	1621 Opos	sumtown E	stauffer Pike. Fre	derick		-
ian ical iner		Immediate Cause (Final disease or condition resulting in death)	- a	FUSK	Tous CI	- mai - 1/2	1 1		1/2 2 0	1 11 11 11 1
l-transit	xamlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	consequence of):		nivace of	strutiv	603,		4 10 y 1.
70	Aedical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	consequence of):		nivere of	3110000	5024		4 10 / 1.
70	ca	Cause (Disease or injury that initiated events	b. Due to (or as a c	consequence of): consequence of): consequence of): pregnancy Fetal death 3	□Ectopic pregnanc □ Other (specify) _		2110000	23d. Ľ	Date of deliver	
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Registrar

			Please I		t in Black in ryland / Depa			•	_	
		•	1 - State Registrar	State of Ivia		rtificate of			g. No 2 0 0 5	12651
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	- 100 day 100 ft.3	3. Time of Death
	Physici /Medio		Dorothy Singley					March	27, 2005	1:58 A M
	Examin		4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	h
			4201 Bill Moxley R			Mt If Under 1 Year	. Airy If Under 24 Hrs.	0.0	Freder	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director		578-12-5065 Usual Residence of Decedent		88 Yrs.			Nov. 22,	1916 wasr	nington, DC
	ehow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f	ctor	Maryland Freder	rick	Mt. Ai	ry				1 ☐ Yes 2X No
	라 다 6 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	e 23a	Funeral Director	4201 Bill Moxley F	Rd . 12. Was Decedent 8	Suprin II C 12	Was Deceded of M		acifu Vas or No-	United Sta	
	Item Item	'n.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	
036	urs af	٥	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2x ☐ No	Specify:		Specify: Wh	nite
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Iteme 23a or 28a-1 ehow ta Medical Exatol attribal te trofilled at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of work	ing 1	6b. Kind of Business/I	Industry
2	han *	Jd I	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired	d)			
	should be filed withlr nd Mental Hygiene. marked other than matic event, tra Mi		12 17. Father's Name (First, Middle, Last)		Hom	emaker	18. Mother's Name	e (First, Middle, M	Own Hon laiden Sumame)	ne
an	d be ental Ked o	To Be	Walter Disney				Eleanor	Hook		
Maryland	should be ind Mental I	1	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailie	ng Address (Street			City or Town, State, Z	Tip Code)
	42 7 fr		David Holmes		1002	Autumn G	Gold Dr.,	Gambrill	s, MD 2105	54
Baltimore,	permit. Pages 1 am Department of Heeli Importent: if Item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ XCremation 3 ☐ Re	emoval from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other plac	ce)	Date 2	0c. Location - City or	Town, State
Ĭ.	ment tent: t		`4 □ Donation 5 □ Other (Specify)		Frederic					, Maryland
3all	permit. Pa Departmer Importent any Injury once.		21. Signature of Funeral Service License) <u>/</u>		2. Name and Addre			uneral Hom	
	40 = 4 G		222 Par Enter the diverse or compli	cation was caused					t. Airy, M	ID Z1//1 Approximate
			23a. Parl. Enter the disea e, or complied nock, or heart fail of . List only on Immediate Cause (Final	150		A	.9,	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	BREA Due to (or as	a consequence of):	EK_				3 YEAR
	Examiner									
	n #	ner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	consequence of):		·			
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D						
60,	e be executed /sician and e burial-transit	a E	Todaling in dodain, Eddi	Due to (or as	a consequence of):					
687	The law requires that the death certificate be executed to the sace been signed by the attending physician and page 2 should be detached for use as the burial-transit		d	l						
Box (certif nding use as	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of deli	very
	death e atte	iclai	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnant at		□Ectopic pregnancy □ Other (specify) _	γ		Month	Day Year
P.0	at the by the	hys	9 🗆 Unknown	9□ Unknown						
	res that the death cer igned by the attendin be detached for use		Part II. Other significant conditions con	•	it not resulting in the u	inderlying cause giv	ven in Part I.		acco use contribute to s 2 □ No 3 □ Pro	
ord	w requir been si should	ted	DIABETES MEL	LITUS						
Sec.	elaw hasb e2sl	Completed by						24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
alF	n: Th licate r, pag		05.11				00 Pl 4 D4	1 Yes 2	No 1 Li Yes	2X No
of Vital Records,	Physician: The law this certificate has b ral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	nt 2 ER/Outpatier	nt 3 DOA Ott		h <i>(Check only one</i>	nce 6 Other (Spec	cify)
o	ilng Phys .r After this funeral di	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time o		rv at	28d. Describe ho		
ion	Attending ir death. ector: After by the fune	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Da)	r dai) injury		Yes 2 □ No			
Division	ir Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	iry - At home, farm, st :. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	oital or urs afte rel Dir lled in	Cer	**0							4-1
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical			examination and/or in				use(s) and manner as te and place, and due	
	ithin it	Med	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month	h, Day, Year)
	- s + ō			WD		Do	056314		3/28/05	
	6		30. Name and address of person who co		eath (Item 23a) (Type,		RIVE FR	12 DEP 10 =	MD 217	n2_
			BINDU GEDRGE	40		INSON D	NVE TR		12921	
	Sta Registi		31. Date filed (Month Park Yaar) 0 20)05 Jacobstra	r's Signatur	200				

			For	State of Ma			lealth and Me	•	•	
			1 - State Registrar			rtificate of			.N.2005	12652
	Physic	ian	Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Ollie Faye Stanle					March	27 2005	4:30 P M
1	Exami	ner	4a. Fecility Name (If not institution, give Calvert Manor Hea		n to t		or Location of Death		4c. County of Deat	h
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)	Rising If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth	Cecil 9. Birt	nolace (State or Foreign
	Director		218-34-1673 Usual Residence of Decedent	□M 21X F	70 Yrs.	Months Days	Hours Min.	(Month, Day, Y 2bruary	23, 1935	nplace (State or Foreign untry) NC
	anylan show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	the M	ecto	MD Cecil 10e. Street and Number		Elkton	1				1 □ Yes 2 No
	with Ja or	2	125 Friendship Ro	and		10f. Zip Code 21921		10g	. Citizen of What Co	untry?
	death	era	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13. \		lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No-	USA 14. Race - Ame	ican Indian.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or items 23a or 28a-f show event, tre M. Alc. I Exertire russt be notified.	Completed by Funeral Director	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:	1	f Yes, specify Cub 1 ☐ Yes 2 X No	an, Mexican, Puerto Ri Specify:	ćan, etc.)	Specify: Wh	o, etc.
5-0	72 h	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done	during most of working	16	b. Kind of Business/l	ndustry
121	within Bne. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	d)		Stato Hu	.,
<u>q</u>	filed Hygi ther		17. Father's Name (First, Middle, Last)	<u> </u>	100	1 correc	18. Mother's Name (First, Middle, Ma.	State Hw	<i>j</i> •
<u>lan</u>		To Be	Thomas Griffin				Bessie Sta			
lary	and and is m		19a. Informant's Name/Relationship (T	., .	19b. Mailin	g Address (Street	and Number or Rural I		ity or Town, State, Z	ip Code)
	1 and 2 Health tem 27		<u>Robert T. Stanlei</u>				ip Road, Ex		D 21921	
Baltimore,	Pages 1 ar	1 2	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □X		20b. Place of Dispos cemetery, cren			2005	c. Location - City or I	
턡	mit. Pa partmen cortent: injury injury		'4 ☐ Donation 5 ☐ Other (Specify,		Friendly	Grove Ba	ptist Cemer	tery we	st Jeffer	son, NC
Ba	permit. Pages Department of I Importent: If it eny injury or o		Kichard Z.	Good	e 111	1 S. Que	ss of Facility R.T. en St., Ri	sing Sun	, MD 2191	ome, P.A. 1
			23a. Pert 1 Enter the disease, or comp shock or heart failure. List only of	ications hat caus the ne days e on each I e.	ne death. Do not ente	er the mode of dyin	ng, such as cardiac or r	espiratory arrest		Approximate Interval Between Oaset and Death
	Physician /Medical		Immediate/Cause (Final disease or condition resulting in death)	a. I EMER	STA (OF Hr	245IMED!	5 14	e I	Syears
	Examiner			Due to (or as a c	consequence of):			4	-11	1
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):					
9	e be executed /sician and e burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying	c						
760,	e exe sian a urial-1		resulting in death) Last	Due to (or as a c	consequence of):					
	cate b	dicai		d						
9 X	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome of	oregnancy	-84		200		
Вох	Jeath atter	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 [4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliv Month	ery Day Year
P.O.	t the c by the achec	hys	9 Unknown	9□ Unknown						
Vital Records, F	sign d be	by	Part II. Other significant conditions co	ntributing to death but r	not resulting in the un	derlying cause give	en in Part I.	23e. Did tobace	co use contribute to	he cause of death?
သူ	law requas been 2 should	piet						24a. Was an	24b. Were aut	opsy findings available
	The zate h page	Completed						autopsy performed 1 ☐ Yes 2 🛣	? death?	mpletion of cause of
<u> </u>	ician: sertific ector,	Be	25. Was case referred to medical examiner?				26. Place of Death (C		J	
of	Phys this c	.T	1 ☐ Yes 275 No	lospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient 28b. Time of		Thursing Home		6 ☐Other (Speci	(y)
o	rding th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yo	ear) Injury	28c. Injun Work	vat 280 (? Yes 2 ∐No	. Describe how in	njury occurred	
Division of	Attendi r death. ector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, stre			Location (Street	and Number or Run	al Route Number.
	s after s after bl Dire bd in by	Cert	4 Homicide	building, etc. (Specity)			City or Town, Si	tate)	
	To the Hospitel or Attending Physician: The law within 24 Hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1. Certifying Physical Exami	sician: To the best of mer: On the basis of ex and manner stated	amuration and/or inve	occurred at the timestigation, in my op	ne, date and place, and pinion, death occurred	due to the cause at the time, date	e(s) and manner as s and place, and due t	tated. the cause(s)
	To the To the comp	M	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month,	Day, Year)
			> Noul > 4			DOC	758354		3/29/0	
	5		30. Name and address of person who co	impleted cause of deat	h (Item 23a) (Type, P	rint)	1.2	0	Livita	040
			31. Date filed (Month, Day, Year)	22. Registrar's	Signature #	DLONIK	x ung	1 KISIN	5 Jun,	1,m 91d11
	Sta Registra		MAR 2 9 2005	Service .	Signature	And the second	-			

	•	For State Registrar		Cei	artment of H <i>rtificate of L</i>	Death	F	Reg. No. O O O	20 5 67 40 200 L
Physici		1. Decedent's Name (First, Middle, Last) Jack Richard Stolt	7				2. Date of Dea Month March 2	Day Year	3:50 A M
/Medic Examir		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death	naren 2	4c. County of Dea	
		12025 Quarum Place			Bowie		,	Prince G	
Funeral Director		3/7-32-6843	7. Age (f.	76 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day July 9,	y, Year) 1928 Was	thplace (State or Foreign ountry) hington, DC
and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
Maryl -f sho	ţō	Maryland Prince Ge	orges E	Bowie					1 X Yes 2 □ No
h the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
23e c	raiD	12025 Quarum Place			20720			USA	
n 72 hours after death with the Maryland "natural", or Items 23e or 28a-1 show calcal Examinating the mylling at	by Funerai	1 ☐ Never Married 2 💢 Married	2. Was Decedent Eve Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: ✓	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	- 14. Race - Am Black, Whi	te, etc.
72 B B	ompleted b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade	ation		dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	king	16b. Kind of Business	
	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	1	tor Mecha			Federal Go	vernment
filled Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
2 should be and Mental is marked c	5	Louis William Stol				Margare			
d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type Pamela J. Stoltz/						er, City or Town, State, ${ m y1}$ and ${ m 2072}$	
s 1 and 2 of Health item 27 other tru		20a. Method of Disposition			osition (Name of matory or other place		Date	20c. Location - City o	
Pages nent of int: If it		1 ☐ Burial 2 【Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Huntt Cre			/2005	Waldorf, Ma	aryland
permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>once.</u>		21. Signature of Coneral Service License		2:	2. Name and Addres			Evans Fund e, MD 2071	
11 50		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the	e death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory a		Approximate Interval Between
Physician	Į. Į.	Immediate Cause (Final disease or condition	No	insmall	cell lu	ng can	es		Onser and Death
/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):					
	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
outed id ansit	Examiner	that initiated events c							
ficate be executed physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as a c	consequence of):					:
cate b physic the bi	edicai	d							
± 00 m	n/Me	IF FEMALE: 23 23b. Was decedent pregnant 23	3c. If yes, outcome of	pregnancy				23d. Date of de	elivery
at the death by the atte- tached for	hysician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
gned gned	by P	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	underlying cause give	en in Part I.		obacco use contribute Yes 2 □ No 3 □ F	to the cause of death? Probably 4 □Unknown
The faw requires the faw requires that has been singles and the page 2 should the factors of the	ompieted						24a. Was autop perfo	an 24b. Were a prior to death?	utopsy findings available completion of cause of
	e Co	25. Was case referred to medical				26. Place of Dea			s 2 No
ystcia s cert directe	0	evaminer?	ospital:	2 ER/Outpatie	nt 3 DOA Oth	0.0		dence 6 ☐Other (Sp	ecify)
nding Phy th. : After thi s funeral	tion; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	/ear) 28b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe	how injury occurred	
i or Atter after dea Director	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (r - At home, farm, st (Specify)	reet, factory, office		28f. Location (. City or To	Street and Number or F wn, State)	Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical C			xamination and/or in				cause(s) and manner a date and place, and du	
ple in	Me	29b. Signature and title of certifier	, ())	29c. Licens	e number		29d. Date signed (Mor	
of the control			1 1/	<i>I</i>	700	061040		March	25, 2005
To T To T			- 100	1					<i>)</i>
To twith To Com		30. Name and address of person who co Charles M. Rudin,			, Print)	- //i 24/11 - 20		37	

		,	For State Registrar	State of Maryla	•		nt of Health ar te of Death	nd Mental H	ygiene Reg. No. 200	5 12654
	Physici /Medio		Decedent's Name (First, Middle, Last)	MARY AGNE	S SMI	TH		2. Date of I		3. Time of Death 3:00PM M
	Examin		4a. Facility Name (If not institution, give s SUBURBAN HOSPITAL 5. Social Security Number 6. Sex		s. last birthday)	BET	HESDA T 1 Year If Under 24		4c. County of De MONTGON	
	Funeral Director			IM 2□F 85	Yrs.	Months	Days Hours	APRIL	Day, Year)	MARYLAND
	Maryland f show	٥	10a. State 10b. County VA FAUQUIER		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 💢 No
	h the f	Irect	10e. Street and Number			10f. Z	p Code		10g. Citizen of What	Country?
	ath will	raiD	7701 GREENWICH RO				181		U.S.A.	
036	72 hours after death with the Maryland natural', or itema 23a or 28a-f show ilsal Examinat must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	Was Deco f Yes, sp 1 🗌 Yes	edent of Hispanic Origin ecify Cuban, Mexican, I 2 No Specify:	n? (Specify Yes or ! Puerto Rican, etc.)	14. Race - Ai Black, W	merican Indian, hite, etc. WHITE
21215-0036	within ane. than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L	kind of w	ual Occupation ork done during most of use retired) KFR	of working	16b. Kind of Busines	
	ould be filed Mental Hygis arked other	To Be C	17. Father's Name (First, Middle, Last) THEODORE PROBST				18. Mother's	Name (First, Midd HOFFMAN	le, Maiden Sumame)	
Maryland	and and aum	Ъ	19a. Informant's Name/Relationship (Ty) PAMELA ANN SMITH	•		-		or Rural Route Num	ber, City or Town, State	
Baltimore,	0 0 = =		20a. Method of Disposition 1 Burial 2 Typeremation 3 R 4 Donation 5 Other (Specify)	emoval from State	Place of Dispo cemetery, cren	sition (Na natory or	other place)	Date	20c. Location - City FALLS CHUF	or Town, State
Balti	permit. Pag Department Important: any injury c		21. Signature of Funeral Service License		22	. Name a	nd Address of Facility	NATIONAL	FUNERAL HOM HURCH, VA 2	ΙE
)e	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	ath. Do not ent			irdiac or respiratory	arrest,	Approximate Interval Between Onset and Death WEEK
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
68760,	icate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
.O. Box 68	death certiff e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3 ⊑	Ectopic Other (s	oregnancy pecify)		23d. Date of o	lelivery Day Year
S, D	signed be de	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	nderlying	cause given in Part I.		f tobacco use contribute]Yes 次汉 No 3□	to the cause of death? Probably 4 Dunknown
Record	The law requate has been page 2 shoul	Completed	HYPERNATREMIA					per	ts an opsy prior t death 1 1 1	
Vital		BeC	RENAL FAILURE 25. Was case referred to medical examiner?				26. Place of	f Death (Check only		20110
of	ng Phys fter this ineral di	၉	1 Yes 2 No H	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		28c. Injury at Work?	28d. Describe	sidence 6 Other (Special of the following occurred)	pecify)
Division	or Attendent fler deat lirector: n by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	M eet, facto	1 ☐ Yes 2 ☐ No	28f. Location	(Street and Number or own, State)	Rural Route Number,
	Hospit 24 hour Funera stely fills	edical C	29a. Certifier (Check only one) Certifying Physical Certification Physical	ician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurre estigatio	dat the time, date and p n, in my opinion, death	place, and due to th occurred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				c. License number		29d. Date signed (Mo	nth, Day, Year)
	(10)		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type		D0060117		3/26/2005	
K				QQQ1 MEDICAL	CENTER	זמח	VE ROCKVII	LE, MD 2	0850	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2005	2. Registrar's Sig	Span .	R)		, , , , , ,		

State of Maryland / Department of Health and Mental Hygiene [] [] 5 2655 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year HELEN ELIZABETH STUNKLE APRIL 2005 3:55 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15341 SIXES ROAD **EMMITSBURG** FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) JULY 28,1909 **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 💢 F Director 95 213-42-5608 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location rai', or items 23a or 28a-f ehow Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD FREDERICK **EMMITSBURG** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 15341 SIXES ROAD 21727 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
snt: if Item 27 is marked other than "natural", or Items 23sury or othar traumatic event, the Mydical Examinan must U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE δ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ EDGAR ALLEN VALENTINE SALLIE CATHERINE BAUMGARDNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARA A. STEWARD/ DAUGHTER 1006 HARRISON DR., LAUREL, MD. 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOUNT OLIVET CEMETERY 4/11/2005 FREDERICK. MD. 21. Signatus of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME Mn m 210 W. MAIN ST., EMMITSBURG, MD. 21727 23a. Par / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause or pach line. Approximate Interval Between Onset and Death Imme ate Cause (Final diseare or condition resulting in death) Alle roscles oter (ard (o vaxalar disease Physician 70 YIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of): Examiner certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ till reclotion NoI 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? page certificate 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☒ No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ٩ To the Hospital or Attending Pl within 24 hours after death. To the Funeral Diractor: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊠Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) NA-0+37758 400 lette ny APRIL 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McGLAUGHLIN, M.D. 524 S. WASHINGTON ST., GETTYSBURG, PA. 17325

DHMH 17 Rev 1/2001

State

Registra

MICHAEL J. 31. Date filed (Month, Day, Year)

APR 1 2 2005

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** April 3, 2005 Charles Randolph Scott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 811 Trail Avenue Frederick
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 54 Yrs. Sept. 25, 1950 Maryland Director 214-54-2464 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow a 23a or 28a-f shov 1X Yes 2 □ No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 811 Trail Avenue 21701 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or Itama 11. Marital Status the Madical Examiners Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itar any injury or other traumatic event, the Mudical Examinat 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th truck driver transportation/hauling 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alfred Lynn Scott Viola Burris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kristy Scott, daughter 811 Trail Avenue, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 4/7/2005 Frederick, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facilit Keeney and Basford Funeral Home M00999 106 East Church Street, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause of each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Metastatic Lung Cancer Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner attending physicien and for use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy the atter in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death Certification: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. al or Attend s after death 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Monfh, Day, Year) 29b. Signature and title of certifier physo- Drive & dell MD21702 person who completed cause of death (Item 23a) (Type, Print) B 40 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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			Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
	Physici		MARGARET	L. THOMPSON	V			MARCH	1 ^{Day} , 20	05	4:Am M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Deat	h	4c. County of	of Death	·
		**	6740 Townbrook	Drive, #A		Gwyr	nn Oaks			TIM	ORE
	Funeral Director		5. Social Security Number 6. Sex 223-36-4583	7. Age (In yrs. last 73	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Mar. 2	, 1931	Coun	lace (State or Foreign try) rginia
	pu ≱		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation			_	1	Od. Inside City Limits
	sho	ä	MD Montgo			thersbur	a				1⊈Yes 2∏No
	28a-f	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Coun	trv?
	with	늅	8710 Emory Gr	Frank Over		208	277		U.S		.,.
	eath	era		2. Was Decedent Ever in U.S.	13.	Was Decedent of His If Yes, specify Cubar		pecify Yes or No			an Indian,
	iter d	Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No	1			o Rican, etc.)	l l	, White,	
036	urs al	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes ¾ ☐ No	Specify:		Specify:	Bla	ack
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215	hin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	,	9	Mano	r C	are of
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yla	Menid Menid Barke	2	Roosevelt					h Thoma			
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Men		19a. Informant's Name/Relationship (Typ			ng Address (Street a			-		
	1 and 2 Health em 27 i		Ruth Gibson (I			0 Emory		Date	20c. Location - 0		
Baltimore,	of of		τ⊈Burial 2 ☐ Cremation 3 ☐ Re	amoval from State		natory or other place					
ţ	Department Department Important: I mn injury o		'4 □Donation 5 □ Other (Specify)		-4-	Ch. Cen		3/05	South	птт	ı, va
Bal	permit. Departir Importa any inja		21. Signature of Funeral Service License		/ X s	nowden 1 46 N. Wa	Tuneral	Home	P.A. 20	850	27.7
	40244		23a. Part1. Enter the diseas , or complic	valide that caused the death.	$\sqrt{2}$	46 N. Wa	shingt	on St,	KOCKV1	TTE	, MG Approximate
			shock, or heart failure. List only on	e cause on each line.	J			or roophatory at			Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metastatic c		gibcatein	ona				2 months
	Examiner			Due to (or as a consequen	ice of):						
		-G	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):						
	nsit	두	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
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B	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of death		Other (specify)			Mon	th	Day Year
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S, F	ires tha signed I d be det	oy P	Part II. Other significant conditions con	tributing to death but not resultin	ng in the u	nderlying cause give	n in Part I.				e cause of death?
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Records,	aw re as be 2 sho	Completed						24a. Was	an 24b. W	ere autor	osy findings available inpletion of cause of
H	ysiclan: The lav Is certificate has director, page 2	E O						perfo	rmed? de	eath?	2₩ No
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f \		2	examiner? 1 □ Yes 2⊠ No	ospital: ↑ ☐ Inpatient 2 ☐ ER	/Outpatier	nt 3 DOA Othe	4 Nursing H	łome Ś⊠Rosi	dence 6 🖾 Othe	ON S r (Specify)
n of	Jing Ph J. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time o	f 28c. Injury Work		28d. Describe I	now injury occurre	d	
<u>io</u>	andir sath. or: Al	atle	2 Accident investigation			M 1 🗆 Y	res 2 □ No				
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, sti	eet, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rura	Route Number,
	ral D										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		icien: To the best of my knowle er: On the basis of examination and manner stated.							
	the the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed	(Month, I	Day, Year)
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	10		DAVID GERBER MD	JOHNS HOPKING H			WORTH BROK	DWAY B	ALTIMBRE.	MD	21231-2410
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Myra Kay Toomey Mar. 23^{Day} 2005 11:50a [™] /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Jun. 25, 1936 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Days Hours 1 M 2 M F Months Min. Director 68 Yrs. 068-30-9153 NY Usual Residence of Decedent Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic evant, the Medical Eraminer must be rigitlied at MD Anne Arundel Director Severna Park 1 ☐ Yes 2 ☑ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Greenforest Drive Items 23a 21146 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 ia markad othar than "natural", or Ite Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold McClure Mildred De Kay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a i: If itam 27 ia r or other trau William Joseph Tommey/Husband 505 Greenforest Drive, Severna Park, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Metro Crematory or other p 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. `4 □ Donation 5 □ Other (Specify) Baltimore, MD Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Hemorrhage days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physiclan/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. as the t IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 this certificate has autopsy performed? 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Division 1 Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of partitier 29c. License number 29d. Date signed (Month, Day, Year) StrendBech, th 46052 3/23/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S | Oliva Black, TWO 2001 Wedical Panhway, annopolos, MD 32. Restrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 27 2885 **Physician** JOSEPH ROBERT TISCORNIA 2:56 A^M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1∰M 2□F 57 New Jersey 1948 150-40-0678 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State ral', or items 23a or 28a-f show Examiner must be notified at 1 ☑Yes 2 ☐ No Morris Mendham Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 07945 USA P.O. Box 61 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. t 1. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 is marked other then "natural", or Ite 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other then "natural traumatic event, the Medical Self Employed Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs. Proprietor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helene Rezler Joseph Robert Tiscornia, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 73 Chestnut St. Morristown, NJ. 07960 John Tiscornia/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 28 Burial 2 Cremation 3 Removal from State Mendham, NJ. 04-02-05 permit. Page Department or Important: If eny injury or once. Hilltop Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 23a. Part. The run disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic ocular melanoma 12/04 - present **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 635035 March 28, 2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892 . Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 0 2005 Registrar

	•	For State Registrar		State of M	laryland		rtment of l				giene Reg. No.	005	12660
Physicia /Medica	n al	1. Decedent's Name (F	L. Tes	terman						2. Date of De Month	8 Day	Year 2005	
Examine Funeral		4a. Facility Name (If no UNIVCVSTY & 5. Social Security Number	F Maryl	and Med		Cutcy ast birthday)	If Under 1 Year	nove	er 24 Hrs.	8. Date of Bir (Month, Da	Be th	ounty of Dea 1 + Mc 9. Bir	P (1
Director		246-38-823 Usual Residence of De 10a. State 10	30	□M 2 X F	78	Yrs.		Flours	iviiri.	1/25/1	927	Nor	10d. Inside City Limits
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with th	Dire	1301 Heaps					10f. Zip Code 21160					en of What Co JSA	ountry?
ali, o	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Deceden Armed Forces 1 Tes 2 If Yes, Give Year or Dates	K √o		Vas Decedent of I Yes, specify Cub			ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whi	
within 72 ho ene. then "natur	Completed		Decedent's Eronly highest gra		5+)	(Give : life. L	lent's Usual Occu kind of work done DO NOT use retire WElder	durina m	ast of worki	ing		d of Business Ianufac	Undustry
ial yialing with	To Be C	17. Father's Name (Fin Din Barks						1	_	(First, Middle Mae Br		Sumame)	
		19a. Informant's Name Ronald E					g Address (Stree. Heaps R					Town, State, . 21160	Zip Code)
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre		20a. Method of Dispos	ition Cremation 3	Removal from State	CE	lace of Disposemetery, cren	sition (Name of natory or other pla Cemetery	1	C	/2005	20c. Loc	ation - City or	
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Physician /Medical Examiner be prival-transit Physicien and Phy	icai Examiner	Immediate Cause (Fir disease or condition resulting in death) Sequentially list condition and if any, leading to immediate. Enter Underlyi Cause, Disease or might initiated events resulting in death) Las	tions, adiate ng	b. Due to (or a c. Due to (or a d	s a conseque	uence of):	rct						Interval Between Onset and Death
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sicien: The law re certificate has be lirector, page 2 sho	Completed	Hypertent		Christ p	ulma	nem	disase.			1 ☐ Yes	psy ormed? 2 No	prior to death?	utopsy findings available completion of cause of
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/Medi	cal	Robert		Paul		Valentine			Jr.		April	9,	2005		03:20 P
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State Registrar TAIDI

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31. Date filed (Month, Day, Year)

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801 32. Register's Signature Frederick

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	Physic /Medi		Decedent's Name (First, Middle, La JOHN WILLIAM		JR				-		2. Date of De Month MARCH		2 0 0 5		of Death
	Exami		4a. Facility Name (If not institution, gi FREDERICK MEN					Town, or	Location o	of Death			unty of Death	1	
	Funeral Director		579-30-6641	Sex 7.7 1 M 2 □ F	Age (In yrs. last I 76	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug • 4	th iy, Year) 1928	9. Birth	ntrv)	e or Foreign
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Everythetermat be regittined at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washing 10e. Street and Number	ton	10c. City, To		ing								City Limits
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9000	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Eventual PADE.	d by Funerai (11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force: 1X1 Yes 2 [If Yes, Give Year or Dates	o? WWII No Korea	'	Was Deced f Yes, spec 1 ☐ Yes 2	ify Cubar	spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, ec <i>ity:</i> Wh		
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	and 2 sho salth and I n 27 is ma		19a. Informant's Name/Relationship (Patrick Wheeler (4681	Newi	ngto	nd Numbe n Roa	or Rura	Anoute Number	er, City or Too	wn, State, Zip 21755	Code)	
Baltimore,	Pages 1 ment of He ant: If iten ury or oth	10	20a. Method of Disposition 1			ery, cren	sition (Nam natory or ot rg Cr	ner place			ate /05		sburg,		land
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Lice	ns e		RŐ	BERT 1	Address E. DA	ALEY MARKE	& S T ST	ON FUNI	ERAL HO	OMES.	P.A.	
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P.O. Box 68	taw requires that the death certifica as been signed by the attending ph 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 ∏Fetal deat at time of death		Ectopic pre Other (spe					100	Date of delive	r y Day	Year
	w requires that been signed b should be deta		Part II. Other significant conditions of		but not resulting		derlying ca	use giver	in Part I.				ontribute to th		
II Reco	The ate h	Completed	1+710	LENZIO	N					_	24a. Was a autops perfor	SV	b. Were autop prior to con death? 1 Yes	npletion of	s available cause of
Division of Vital Records,	ng Pl	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpat 28a. Date of Inj (Month, D	ury 28b.	utpatient Time of Injury		Other c. Injury a Work?	4□Nur	sing Horr	(Check only or le 5 Reside 8d. Describe he	ence 6 🗆 C		<i>'</i>)	
DIVIS	in die	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	200. Flace 01 II	ijury - At home, f tc. (Specify)	arm, stre	et, factory,	office		2	8f. Location (Si City or Town	treet and Nur n, State)	mber or Rura	Route Nur	nber,
	To the Hospital or within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1	ysician: To the besi niner: On the basis of and manner s	or examination ar	e, death nd/or invi	occurred at estigation, i	t the time n my opir	, date and nion, death	place, a	nd due to the co	ause(s) and r ate and place	manner as sta e, and due to	ated. the cause(s)
	To T Com	Z	29b. Signature and title of certifier Davi J Agyalle	(1) No. 1	•			License r		. (ned (Month, L	Day, Year)	
10)tl		30. Name and address of person who	completed cause of	death (Item 23a)		rint)		6201			3/30/			
	Sta Registra	te	DAVID AGYAKO - WILL 31. Date filed (Month, Day, Year) APR 0	32. Regist	SW 715	M	Assa.	<u> </u>	701	, m	CT) 5/4 CI	cmo	(217	-01)	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Registrar 1. Decedent's Name										2. Date of D	eath			3. Time of I
ın	Karen Di			_							Month	2.7 Day	2005 ^{Ye}	ear	1940
al	4a. Facility Name (If				nber)		4b. C	City, Town, or	Location	of Death			County of E	Death	
er	Frederick						Fr	rederio	ck			Fr	ederi	ck	
	5. Social Security Nu		6. Sex	1 7	7. Age (In y	rs. last birth	Mont	nder 1 Year ths Days	If Under Hours	Min.	8. Date of B (Month, D	irth ay, Year)	9.	Birthpla Counti	ace (State or
	213-76-06		1 □ M	2121	36	Y	rs.			D	ecembe	r 31,	1968	A.	Labama
1	Usual Residence of 10a. State	10b. County			10c.	City, Town	or Location							10	d. Inside City
٥	Maryland	Fred	erick		T	hurmo	nt								1 Yes
Director	10e. Street and Num	nber					10f.	. Zip Code				10g. Citi	izen of Wha	t Count	ry?
ai	415 01d (Oak Pla						21788					S.A.		
Funeral	11. Marital Status			Was Deced	ces?	n U.S.	13. Was De If Yes,	ecedent of Hi specify Cuba	ispanic Or Mexica	rigin? (Spi in, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - A Black, V	Amenca White, e	
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3	Ralph Dra										rmont,			217	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 25, 3:15 P MARCH 2005 WAKEFIELD HENRY **ERNEST** /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SILVER SPRING MONTGOMERY MARINER HEALTH CENTER If Under 1 Year If Under 24 Hrs.

14-14-1 Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days **X**☐ M 2☐ F Yrs. FEB. 11, 191<u>5</u> OHIO 90 Director 270-16-2633 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f ehow the Medical Exacultural he notified at 1 Yes 2 No Director SILVER SPRING MONTGOMERY MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20902 or itame 23a 901 ARCOLA AVE. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filad within 72 hours aftar d al Hygiene. other than "naturei", or itan 1 TyYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: 42-946 à 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICAL BOOKS WRITER 12 should be filad v h and Mental Hygie 7 is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should b Department of Health and Mente Important: If item 27 is marked any injury og Athar treumatic ev once. POLEY MARY FREDERICK W. WAKEFIELD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1805 HERMITAGE DR., FLORENCE, AL. 35630 JOHN WAKEFIELD/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) MAPLE GROVE CEMETERY 3-30-2005 VERMILION, OHIO 22. Name and Address of Facility 21. Signature of Funeral Service Licenses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 YEAR CANCER OF PAROTID GLAND Enysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be axecuted physician and s the burlal-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, been signe þ 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X**☐ No Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation s after dec. •aj Director: Afr 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MARCH 28, 2005 Coxella-D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 FARRAGUT AVE., KENSINGTON, MD. 20895 ROSENBAUM, M.D. N. BARRY Registrar's Signature 31. Date filed (Month, Day, Year) State 30 2005 Registrar

			For State Registrar	State of M	larylan d		artment rtificate			and M		giene Reg. No.	005	12666
			Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia		Janet Lenma	n Plummer	Watki	ns					March	29,	2005	4:06 A M
	/Medic Examin		4a. Facility Name (If not institution, giv						Location o				ounty of Death	
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П	Funeral		Social Security Number 6. S	6ex 7. A 1 □ M 2	Age (In yrs. la		If Under '	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)	Col	pplace (State or Foreign untry)
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	and ₩		Usual Residence of Decedent 10a, State 10b, County		10c. City,	, Town or Lo	cation							10d. Inside City Limits
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	ns 2;	Funeral	11. Marital Status	12. Was Deceder	t Ever in U.S	3. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.))- 14	I. Race - Amer	
٥	or Item	Fur	1 Never Married 2 Married	Armed Forces 1 Yes 2 1 If Yes, Give		1	1 Tes, speci 1 ☐ Yes 2		Specify:	i, rueito	nican, ec.		Black, White	a, etc.
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	as 1 and 2 of Health litem 27 l		20a. Method of Disposition			ace of Dispo	sition (Nam	e of			ate	20c. Loc	ation - City or	Town, State
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Baitimore,	permit. Pagas 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lice	_							P.A.,	Funor	n 1 Home	`
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٥ ×	leath certificate attending phys	Physician/Med	IF FEMALE:	23c. If yes, outcon	ne of pregnar	nev						25	3d. Date of deli	verv
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<u> </u>	The law requires that the death to has been signed by the atter bage 2 should be detached for u		Part II. Other significant conditions	contributing to death	but not resu	liting in the u	nderlying ca	ause give	en in Part I		23e. Did 1	tobacco us	e contribute to	the cause of death?
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וסר	ding Ph. h. After th funeral		27. Manner of Beath 1 ☐ Matural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Day Year)	28b. Time o	f 2	8c. Injun Work	at k?		28d. Describe	how injury	occurred	
<u> </u>	uttendir death. ctor: Af y the fu	atlo	2 Accident investigation				М	1 🗆 '	Yes 2					
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	ottal ours af	O			-1 -1					d =12.22	and due to the		and mannar as	stated
	To the Hospital or Attending Physician: within 24 hours after death. To tha Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	of examinat	ion and/or in	n occurred avestigation,	in my o	ne, date an pinion, dea	ith occurr	ed at the time,	date and	place, and due	to the cause(s)
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	F 3 F 8		1660	Sant	lih	mi	2	0	351	18	3	Mas	1/2	3 20005
	0,		30. Name and address of person with	completed cause.o	of death (Item	23a) (Type.	Print)	1	4			100	and,	1,000
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	Registi	ar			Carlot d	A STATE OF THE STA		7						

		•	For State Registrar	State	of Maryla		artmen					giene	005	126	67
			Negistrar Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath		3. Time of	Death
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	/Medic		4a. Facility Name (If not institution				4b. City,	Town, or	Location of		1101.011		county of Death		<u> </u>
	Examin	er	2715 Nicodemu					West	mins	ter			Carrol:	l	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday	If Under Months		If Under Hours		8. Date of Birt (Month, Day	h v. Year)	9. Birth	place (State o	r Foreign
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	P .		Usual Residence of Decedent		100 /	City, Town or L	coation							10d. Inside Ci	tv Limits
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Madical Examinat must be natiliad at	Completed	15. Decedent (Specify only highes	's Education	4) .	16a. Dece	edent's Usua e kind of wo	al Occupa	ation during mos	t of workin	ig.	16b. Kin	d of Business/l	ndustry	
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Z	should be nd Mental marked (၉	William E. W		, SI	10h Mai	ing Addross	(Stroot a					Town, State, Z.	in Code)	
Maryland	2 8 8		19a. Informant's Name/Relations Marie Lutz/dau								Westmi			21157	
	1 and Health em 27 ther t		20a. Method of Disposition	J	20b	. Place of Disc	osition (Na	ne of	1		ate		ation - City or 1	own, State	
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Baltimore,	perrit. Pages Department of It Importent: If ite any injury or of		' 4 □ Donation 5 □ Other (S	100000000000000000000000000000000000000						-	and Ch			T-IID	
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J Of	g Ph	T iu	27. Manner of Death	/A.A.	te of Injury onth, Day Year	28b. Time Injury	of	28c. Injury World	y at k?	2	28d. Describe	how injury	occurred		
io	Attending In death. ector: After by the funer	atio	1 Natural 5 Pendir investi	gation			М		Yes 2□						
Division	or Attendate after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Pla	ce of Injury - A Iding, etc. (Spe		treet, factor	y, office		2	28f. Location (: City or To		l Number or Ru	ral Route Num	ber,
	itel or irs afte rel Dir iled in			1			67			- I			-4	etato d	
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	thin 2 the 1 the 1 mplet	Medical	one) 29b. Signature and title of certifie		anner stated.		29	c. Licens	e number			29d. Date	signed (Month	, Day, Year)	
	1 × 1		M. AA					033				3	188kx		
	Cen		30. Name and address of person	who completed of	use of death (tem 23a) (Turo		000	5 - 0			/	OOKS		
	- '		Stephen Sikors			shingto		d E	Westm	inste	er, MD	2115	57		
	Sta	ate	31. Date filed (Month, Day, Year)	32	. Resistrar's Si	4	1								
	Regist		MAR 2	9 2005	Alague	J.	group								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Wigfall 10:30 P M Austin 23 2005 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hyattsville 7511 Courtney Place If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1931 Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1⊠M 2□ F $\overline{2}'1$ December 73 South Carolina 577-42-2635 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 1 Yes 2 □ No Director MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7511 Courtney Place 20785 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ⊡Yes 2□NoAirforce If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Dental Lab. Technician Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mattie Mae Johnson Wigfall Archie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret J. Wigfall/Wife 7511 Courtney Place Hyattsville, Maryland 20785 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Arlington Veteran's 3/31/05 Arlington, Virginia 21. Signature of Funeral Sacri 22. Name and Address of Facility J.B. Jenkins Funeral Home 17474 Landover Road Landover, Maryland 20785 Tanh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Vervs Due to (or as a consequence of): ances Sequentially list conditions, if any, leaving to infine clate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed) 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes € No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home sidence 6 Other (Specify) 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28d. Sescribe how injury occurred 28b. Time of Natural 2 Accident 5 Pending 1 🗌 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 2005 031774 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6900 Georgia Avenue N. W. Washington, DC Kevin Abbot M.D. 31. Date filed (Month, Day, Year)

State Registrar

24 hours a

To tha

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Cepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Legical at 2018.

Physician

Examiner

attending physician and for use as the burial-tran

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

Baltimore, Maryland 21215-0036



		For Stata	State of Maryla	and / Dep		lealth and M	ental Hygie	•	12669
		Registrar 1. Decedent's Name (First, Middle, Las	t)		runoaro or i	Douir	2. Date of Death	j. NO.	3. Time of Death
Physicia	an			RENFELT	77		Month	Day Year	- 0410AM
/Medic		4a. Facility Name (If not institution, give		KENLEDI		r Location of Death	ALLI	4c. County of Dea	
Examin	er	Washington Count			Hagers			Washing	ton
Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday) If Under 1 Year		8. Date of Birth	9. Bir	thplace (State or Foreign ountry)
Director		219-20-1842 ¹ Usual Residence of Decedent	□M 2\\ F 8	0 Yrs.	Months Days	Hours Mill.	8. Date of Birth (Month, Day, Y) Dec. 23,	1924 Ma	ryland
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene Hygiene in the rither than "natural; or Items 23s or 28s-1 show ant, Ite Medical Ere in the investor notified at		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
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th the or 28	ire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	ountry?
th wi	by Funeral Director	11232 Church Hill	Road		21773			USA	
r dea	nei	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	 Was Decedent of H If Yes, specify Cubit 	lispanic Origin? (Spe an, Mexican, Puerto l	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
or It	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2 🟋No If Yes, Give		1 ☐ Yes 2X No	Specify:		Specify: [J]	nite
hours	q p	3 Widowed 4 Divorced	Year or Dates:	162 Dec	edent's Usual Occup	agtion	16	Sb. Kind of Business	/Industry
n 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	e kind of work done DO NOT use retired	during most of workir d)	ng '`	DD. Killy Of Dusilloss	vindustry
withii ene. than	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)		ratory Tec			Deat of	Arriculture
filed with Hygiene. other than	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's Name			12,2-0-10-10-
uld be flental rked c	To Be	Loy Nelson Wolf				Nettie	Florence	Kline	
s 1 end 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If the 21 is marked other than "natural", or Items 23a or 28a-f show other treumetic event, If a Mudical Eranitret man be notified at	100	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mai	ling Address (Street	and Number or Rura	l Route Number, (City or Town, State,	Zip Code)
end 2 : ealth ar n 27 is		John Warrenfeltz	z/husband	11232	2 Church H	Hill Road,	Myersvi	lle, Mary	land 21773
permit. Pages 1 end 2 Department of Health Important: if Item 27 i any injury or other try	100	20a. Method of Disposition	201		oosition (Name of ematory or other pla			Oc. Location - City or	
ages ant of t: if i		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	LIGHTION STATE	t. Marl	k's Luther	can 4-13-	2005 W	olfsville	, Maryland
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permi Depa impo any ir		1 salt	usith.	K	cicketts F	uneral Ho		sville, M	
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igne bed	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cause gr	ven in Faitt.	1 ☐ Yes	/	robably 4 Unknown
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Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☑ No			ent 3L DOA		me 5 Residen 28d. Describe how	ice 6 Other (Sp	ecify)
fte na	on:	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	/ Wo		ZOG. Describe now	Injury occurred	
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I or Attending after death. Director: Afte	Certification:	4 Homicide determined	building, etc. (Sp	ecify)	street, ractory, onice		City or Town,		
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a, Certifier 1 Certifying Ph	nysician: To the best of my	knowledge de	ath occurred at the ti	me, date and place	and due to the car	use(s) and manner a	s stated.
Hos 24 hc Fun	dicai	(Check only 2 Medicel Exar	niner: On the basis of exam and manner stated.	nination and/or	investigation, in my	opinion, death occurr	ed at the time, dat	e and place, and du	e to the cause(s)
o the ithin i	Medi	29b. Signature and title of certifier	IM		29c. Licens	se number	29	d. Date signed (Mor	oth, Day, Year)
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1 -		30. Name and address of person who	complete cause of death (Item 23a) (Tvo		0000	7	1.7	
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			For State Registrar		State of M	laryland / [rtment ificate			and M		Reg. No 2	Ed .	12670
	Physici	an	1. Decedent's Name (First, Mic	dle, Last) Rut	h	Wiley					į	2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Shirley 4a. Facility Name (If not institut					4b. City, T	Fown, or	Location of	of Death	09-		y of Death	10.0011
		٠.	135 Mechanic					Cum			0431		Alleg	_	
	Funeral Director		5. Social Security Number 216-40-3098	6. Sex 1 ☐ I	/ 2 □ F	ge (In yrs. last birt 64	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Jan 10), 1941	9. Birthi	place (Stete or Foreign ntry)
	and and		Usuel Residence of Decedent 10a. State 10b. Cour	ty		10c. City, Towr	n or Loca	ation							10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygione. ther then "neturel; or Items 23e or 28e-f show the the Medical Evarsh ar must be notified a	ctor	MD Alle	gany		Cı	ımbe	erland	d 						1 ☐ Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number 135 Mechanic	Stroo				10f. Zip		21502	,		10g. Citizen of	What Cou	ntry?
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36	or Ite	by Fur	1 Never Married 2 M		Armed Forces 1 □Yes 2 □ If Yes, Give X Year or Dates]No	1	Tes, speci		Specify:	i, Fueito	rican, etc.)		^{ack, White,} whit	
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Maryland	should be ind Mental s marked o umatic eve	To B	Frank Bible								<u> </u>		Samps		
Mar	and 2 sho saith and n 27 is m		19a, Informant's Name/Relation Michelle Lee	nship <i>(Typ</i> e		ghter 2	. Mailing	Vest	Sec.	ond S	or or Rura Stree	t Cumb	er, City or Town Derland	n, State, Zij	MD 21502
ore,	of Ho		20a. Method of Disposition 1 🗷 Burial 2 ☐ Crematic	n 3 □Re	moval from Stat		ry, crema	atory or ot	her place			Oate 4/8/2005	20c. Location		own, State
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B	permit. Departr Importe any Inj		1/1/10	7	22	0////		108	Vira	inia Av	enue	: Cumber	rland, MD	21502	
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	【.	Due to (01 a	s a consequence	or).								
, 00,	certificate be executed of the physician and the burial-transit	i Exa	resulting in death) Last	G.	Due to (or a	s a consequence	of):				-	//	0	1	
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Box (leath certifica attending ph I for use as th	an/Me	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, outcom	e of pregnancy 2 Fetal death	. 3∏E	Ectopic pre	egnancy			1		ate of deliv	ery Day Year
Ю. В	he death the atten shed for u	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			at time of death		Other (spe					10	Onth	Day Tea:
<u>α</u>	w requires that the de been signed by the should be detached	y Ph	Part II. Other significant cond	itions cont	ributing to death	but not resulting in	n the unc	derlying ca	ause give	en in Part I		23e. Did	tobacco use co	ntribute to t	the cause of death?
ords	equire een sig nould b	ted t										1 🗆			bably 4 □Unknown
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Vital		a	25. Was case referred to med	cal						26. Place	of Deat	1 ☐ Yes h (Check only	2 No	1 🗆 Yes	2 No
of V		To B	25. Was case referred to med examiner? RECEAS	►0 Ho	spital: 1 Inpa		utpatient		_	4 114	ursing Ho		idence 6 🗆 O		fy)
	fel ne	tion	27. Mann of Death 1 Natural 5 Per 2 Accident inve	ding stigation	28a. Date of In (Month, L	Pay Year)	Injury	M	8c. Injun Worl 1 🔲 '	γαι k? Yes 2□		200. 00301100	now injury occo	31164	
Division	spitel or Attendi ours after death. terel Director: A filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be ermined	28e. Place of building,	njury - At home, fa etc. <i>(Specify)</i>	arm, stree	et, factory	, office				(Street and Nun wn, State)	nber or Rur	al Rouțe Number,
Ω	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director; A completely filled in by the fu					st of my knowledge									
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	To To Com	Σ	29b. Signature and title of cert	tier to	01	Sania.	1	290	License	e number	hx-		29d. Date sign	led (Month,	TH DONT
ì	100		30. Name and address of pers	on who con	npleted cause of	death (Item 23a)	(Туре, Р	Print)		10	<u> </u>		MACIL		10001
	111,		Robustiano E	grrera	a M.D.	trar's Signature	em.	Hosp	Ме	d Bld	g Cu	ımberlaı	nd MD 2	1502	
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DHMH 17 Rev 1/2001

ORIGINAL

<u> </u>			1 - For State Registrar		State of N	Maryland		artmen rtificate			and M	F	leg. No.2	05	12671
	Physici	an	Decedent's Name (First, II	Aiddle, Last))							2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic	al	Canpei 4a. Facility Name (If not insti	itution ciuo	stroat and number		Zhu	4h City	Town or	Location o		March 2		ty of Death	1:38 p
	Examin	er	Washington A							Park					
	Funeral		5. Social Security Number	6. Sex	7	Age (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under		8. Date of Birth (Month, Day	1	9. Birth	plece (State or Foreign ntry)
П	Director		058 78 2717		K M 2□ F	65	Yrs.	WOTER	Days	Tiours		Nov. 10,			ina
	and and		Usual Residence of Deceder 10a. State 10b. Co			10c. City	, Town or Lo	ocation							10d. Inside City Limits
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	th the	Directo	10e. Street and Number					10f. Zip	Code				10g. Citizen o	of What Cou	ntry?
	23a c	ralD	2508 Crest A	venue						20785			US		
980	n 72 hours after death with the Maryland "netural", or Itams 23a or 28a-1 ehow watest Examinet must be mutilled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ Divo	Married	12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	s? ⊒No X	1	Was Deced If Yes, spec 1 ☐ Yes 2			gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	14. R B	ace - Ameri lack, White, cify: As	
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Maryland	in to be	Be	17. Father's Name (First, Mid		7 1							(First, Middle,		_	
Ž	should nd Me mark matic	ဥ	Pan Liang 19a. Informant's Name/Rela		Zhu rpe, Print)		19b. Maili	ng Address	(Street a	Fen		Ping Il Route Numbe		Lee m, State, Zij	o Code)
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Ë	Page ment ant: If		'4 □Donation 5 □Oth			Gate									ng, Marylan
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury grother traumatic e once.		21. Signature of Funeral Je	IN	Julo		_ 1	1800	New	Hamps	hire		lver S		Home 5, MD 20904 Approximate
8760,	Associated and hysician are beneather and hysician are proposed to the proposed	Ilcal Examiner	23a Part 1. Enter the diseas shock, or lipart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	List only or	Due to (or a	a consequence a consequence a consequence a consequence as a consequence a	ence of):		4	ne					Interval Between Onset and Death
O. Box 6	that the death certifical ed by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	11,	3c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pro						Date of delive	ery Day Year
ds, P.	es be de	by	Part II. Other significant con	nditions cor	ntributing to death	but not resul	lting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	- 10	ntribute to t 3 🗌 Prot	he cause of death?
Vital Records,	The law ate has b page 2 s	e Completed	End Cerebra 25. Was case referred to me	Stag Vax	e officiella	dne	y I	loui	as	e 26. Place	of Death	24a. Was a autop: perfor 1 Yes	med? 2 X No	prior to co death? 1 \(\text{Yes} \)	opsy findings available impletion of cause of
Į (y si	To B	examiner? 1 ☐ Yes 2 💢 No	F	lospital: 1 Xinpa	tient 2 🗆 E	R/Outpatier	nt 3□ DO	A Othe	r: 4 🗆 Nui	rsing Hor	ne 5 🗆 Resid	ence 6 🗆 O	ther (Specia	(y)
n of	tending Ph leath. tor: After th the funeral		27. Manner of Death 1 Manual 5 □ P	ending	28a. Date of Ir (Month, I	ijury Day Year)	28b. Time o Injury		Bc. Injury Work			28d. Describe h	ow injury occi	urred	
Division	el or Attending s after death. I Director: After d in by the fune	Certification:	2 Accident in 3 Suicide 6 □ C	vestigation ould not be etermined	28e. Place of building,	njury - At hor etc. (Specify)	me, farm, sti	M reet, factory		′es 2 □ h		28f. Location (S City or Tow		nber or Run	al Route Number,
	Hospite 4 hours Funera ely fille	edical C	29a. Certifier 1 Cer (Check only one) 2 Med	tifying Phys dical Exami	sician: To the be ner: On the basis and manner	of examination	vledge, deat on and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the c	ause(s) and r late and place	manner as s e, and due t	stated. o the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of ce	ertifier	41.			29c	. License	number	,	2	9d. Date sign	ned (Month,	Day, Year)
)	2		30. Name and address of pe	in y	mpleted cause of	geath (Item	23a) (Type	Print)	115	146	,	4	1/28/	105	- 1
			357 Uni	Ven	city F	sluzl	W	5	ilu	97	ner	ng l	no	209	0/
	Sta Registr	_	31. Date filed (Month, Day,		105	strar's Signat	re A	artis)				0			

Physicia		- For State Amend Item Registrar 1. Decedent's Name (First, Middle,	Last)						2. Date of De Month		Year	3. Time of Death
/Medic	al		Milton	ZALL	45 Cit 7			- (D 15	Marik		200	
Examin	er	4a. Facility Name (If not institution, Shady Grove Adv			4b. City, Too			of Death		4c. Count		omery
Francis		•		ge (In yrs. last birthda)	If Under 1 Y	Year	If Under		8. Date of Birt	th	9. Birtl	hplace (State or Foreig
Funeral Director		083-30-8496	6. Sex 7. A 14 M 2 □ F	66 Yrs.	Months D	ays	Hours	Min.	Nov. 1	5, Year) 938	N	ew York
2		Usual Residence of Decedent		10c. City, Town or I	coation		,	,				10d. Inside City Limit
anyla show	5	10a. State 10b. County										1 ☐ Yes 2 ☑ N
786-f	ecto	Maryland Monts 10e. Street and Number	gomery	Sir	rer Spr					10g. Citizen of	What Co	
within 72 hours after death with the Maryland ane. Then "natural", or flems 23s or 28e-f show the Madical Examinar must be notified at	Ö	606 Kenbrook Dri	ive		209					United		-
ial Hygiene. nd other then "natural", or liems 23a or 28e-f show event, the Medical Examinat must be notified at	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S. 13	Was Deceden	t of His	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 14. Ra		rican Indian,
or Ite		1 ☐ Never Married 2 XMarrie	Armed Forces ad 1 ☐ Yes 2 1 If Yes, Give	No No	1 ☐ Yes 2 ☐		Specify:		rican, etc.)	Speci	ack, White	hite
E E	Completed by	3 Widowed 4 Divorced	Year or Dates								7.	
"natu	ete	15. Decedent' (Specify only highest	s Education grade completed)	(Giv	edent's Usual C e kind of work o DO NOT use r	done d	luring mos	t of work	ing	16b. Kind of I	Business/	Industry
then then	ф	Elementary/Secondary (0-12)	College (1-4or	r5+) Fr	elance					Ne	wspa	per
Hygi other ent,	a)	17. Father's Name (First, Middle, L		1				er's Nam	e (First, Middle,			•
nd Mental h	To B	Simon Zall					Ra	ay E	pstein			
of Health and Menitem 27 Is marke other treumetic		19a. Informant's Name/Relationsh							al Route Number			
Health tem 27 I		Rochelle Zall,	Wife	Lib a thousand			rive		lver Sp			0902
rages 1 nent of Hi nnt: If iten iry or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from State	e 20b. Place of Dispersion of	osition (Name imatory or othe	or er place	9)	03/2	9/05	20c. Location		Iown, State
ment tent: jury o		'4 □ Donation 5 □ Other (Sp		e Judean	1emoria	I G	ardei	ns'		Olney	, MD	
permit. Pages I Dep rtment of H Importent: If ite any injury or ot once.		21. Signature of Funcial Service L	icensee	T	rchins	ky	Hebr	ew F	uneral 1		20	0.001.0
10 2 8 9		23a. Part Enter the disease, or o	complications that cause	ed the death. Do not e	54 Carr	oll of dvino	St.	, NW cardiac	, Washi	ngton, rrest.	DC :	20012 Approximate
		shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.		,						Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Seph Due to (or a	s a consequence of):	-							Days
xaminer			0 4	amonia					. /			DWTC-
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0	is a consequence of):					7/1	~		
sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с					/	WED BY MEDICAL	EYAMINER		
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physic the t	edicai		d			CEF	RTIFICATIO	-				
attending ph	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. D	ate of deli	very
d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant	at time of death 5	□Ectopic pregi □ Other (s <i>peci</i>				-	М	onth	Day Year
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as the	by F	Part II. Other significant conditio	ns contributing to death	but not resulting in the	underlying caus	se give	en in Part I	ł.	23e. Did t	Δ.	ntnbute to 3 □ Pro	the cause of death?
been sk	ted	Fungearia,	- under fr	uline	faring.	<u> </u>	Sici					
has b	Completed	Hypertensive Ath	erosclerot	ic cardiova	scular	dis	sease	÷;	24a. Was autor perfo		Were au prior to death?	topsy findings availab completion of cause of
	S	atrial fibrillat	ion						1 ☐ Yes	2 No		2 No
ilclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Yes 21100	Hospital: 1 Inpa		• • • • • • • • • • • • • • • • • • • •	Othe	25		th (Check only o		has (Care	-4.)
Physicien: r this certificanal director,	: To	Yes 2 No.	28a. Date of In (Month, E		of unk 28c	-1.	4 1141	ursing Ho	ome 5 Resident			сту)
ding th. : Afte s fune	tion	Accident 5 Pending			М		<br Yes 2.[7]	No \$	Subject	fell		
Attending in death.	ifica	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of I	njury - At home, farm, : etc. (Specify)	treet, factory, o	office	unk	Ī	28f. Location (S	Street and Num	ber or Ru	rai Route Numb uni
tel or s afte el Dir	Certification:	4 - Horneda	Jonaing,					ļ				
lospii hour uner	edical	29a. Certifier 1 Certifyin	Physicien: To the best exeminer: On the basis	st of my knowledge, de of examination and/or	ith occurred at	the tim	ne, date ar	nd place, ath occur	and due to the red at the time,	cause(s) and m	nanner as , and due	stated. to the cause(s)
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medi	one)	and manner				number			29d. Date sign		
Vity CO CO	~	29b. Signature and title of certifier	Olling	E MA	230. 6	01	1000			1	22.0	2 -1-2/-
Ó		1 / tillh /	Cecunical	death (Itam 22a) (Time	Print	7 7	して			7 646	48	; CUIS
		30. Name and address of person of the second	1 200 1	SIHANG	GROVE	1	201	RECI	KUILLE	MO	200	528
		31. Date filed (Month, Day, Year)	32 Agis	strar's Signature	E 10.		0 /					
Sta	ıtė	OT. DUILO III OG (MAINE	2005		SALE E							

2916

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April **Physician** 2005 **AUGUSTA** 12, PHYLLIS **ADAMS** 12:55a M /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cherry Lane Nursing Home Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 19, 1918 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□x Days Months Hours Min, 578-12-7405 86 Director Mass. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Itams 23s or 28s-f ahow the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Prince George's Laurel Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Cherry Lane #11 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð Specify: 3XWidowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If itam 27 is marked othar than "natu
any injury or other traumatic event 16b. Kind of Business/Industry U.S. Air Force Elementary/Secondary (0-12)
Grade 11 College (1-4or 5+) Analyst Welfare Board 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emily Palmer Lewis S. Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Contee Road Pamela Gustafson / daughter #11 Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Amenation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 4/13/2005 Odenton, Maryland 22 Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, Maryland 21. Signature of Funeral Service Licensee / M00770 20707 23a. Part1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lit only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Physician years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, requires should be Rheumatoid Arthrites 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【X【Kknown Completed peen Cerebrovascular Accident 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2★★No 24a Wasan autopsy performed? 1 ☐ Yes 2KXN0 **X**XNo Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4XNursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 🎇 No 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of Injury 28c. 28d. Describe how injury occurred I or Attanding Fafter death. Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To tha Hospital o within 24 hours aft To tha Funaral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 24721 M-1 April 12, 2005

Registrar
DHMH 17 Rev 1/2001

State

0

Laurel, Maryland

14333 Laurel Bowie Road #208

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Sadiq, M.D.

31. Date filed (Month,

Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2005

ORIGINAL

			1 - For State Registrar	State of	Maryland / De	partment o		ind Mental Hy	/giene () ()5 12675
			1. Decedent's Name (First, Middle, Las	st)				2. Date of D	eath	3. Time of Death
	Physic /Medi		Lillian E. Brady					April	Day 12, 20	Year 05 6:20 A M
	Exami		4a. Facility Name (If not institution, give	street and numi	ber)	4b. City, Tov	wn, or Location of		4c. County	0.20
1			8215 Crab Apple C	t.			n Burnie			Arundel
	Funeral	Г	5. Social Security Number 6. S	ex 7	. Age (In yrs. last birthda	y) If Under 1 Y	ear If Under 2	4 Hrs. 8. Date of Bi	irth	Birthplace (State or Foreign Country)
	Director		217 14 0238	□M 2 ∑ F	83 Yrs.	Months D	ays Hours	Min. (Month, D Aug. 5,	ay, Year) 1921	Maryland
	P _		Usuel Residence of Decedent							naryrana
	show	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Ba-f	cto	Maryland Anna Art	undel	Glen Bur	nie				1 ☐ Yes 2X No
	or 2	Dire	10e. Street and Number			10f. Zip Co	de		10g. Citizen of W	hat Country?
	ath w	rai	8215 Crab Apple Co	ourt		21061			U.S.A	
	ter dea	Funeral Director	11. Marital Status	 Was Deced Armed Forc 	es?	B. Was Decedent	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race	- American Indian, White, etc.
36	ours after death with the Marylar rel', or items 23e or 28e-f show Examiner mat be muffled at	by F	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	X No	1 ☐ Yes 2 🔀				White
21215-0036			3 Widowed 4 Divorced	Year or Date						
15	hin 72 he 9. an "netu	Completed	15. Decedent's Ed (Specify only highest gra	de co <i>mpleted)</i>	(Gi	edent's Usual Oc ve kind of work do DO NOT use re	one durina most	of working	16b. Kind of Bus	siness/Industry
12	r than	m C	Elementary/Secondary (0-12)	College (1-4	or 5+)		eur e a)			
9	filed Hygi ther th. I	CO	17. Father's Name (First, Middle, Last)		HOIII	emaker	18 Mother	's Name (First, Middle	Own Hor	
an	⊈ 5	00								7
Maryland	s 1 and 2 should f Health and Men item 27 Is marke other treumatic	70	John Bernard Gre 19a. Informant's Name/Relationship (7		19h Ma	iling Address /St		sa Bierma or Rural Route Numb		Itata Zia Cada)
Z	and 2 stealth are m 27 is her treu		William F. Brady,							
ē,	Hea Hea tem		20a. Method of Disposition	OI. (DO)	20b. Place of Dis	cosition (Name o	creek R	oad Essex		IQ ZIZZI City or Town, State
no	Pages nent of int: If it iry or o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		ate Holly Hi			4/14 2005		
Baltimore,	artme ortan injur		21. Signature of Funeral Service Licen.				ddress of Facility		Dattill	ore, Maryland
Ba	permit. Pages 1 a Department of He Important: If item any injury or oth		12.1.10	1 11	00	Bruzdzii	nski Fun	eral Home	P.A	04004
			23a. Part1. Enter the disease, or cond shock, or heart failure. List only of	lications bat cau	ised the death. Do not a	1407 OLO	d Faster	n Avenue E	<u>ssex, Ma</u>	21221 Approximate
	NAME OF THE		shock, or heart failure. List only of Immediate Cause (Final	_	1 4	1	d) ing, 500 in 25 0	ardiac or respiratory a	iresi,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		ehydro	tion				1 week
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		e.	Sequentially list conditions, if any leading to immediate	b. Due to (or	as a consequence of	<i>r</i> –	Johan	160		1 month
	uted 1 Insit	min	if any leading to immediate cause. Enter Underlying Cause (Disease or injury							
Ć,	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					
8760,	icate ba executed physician and s the burial-transit	dicai		d						
68	tificat ig phy as th									
Вох	cer dir se	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco					23d. Date	of delivery
	D 0 D	Physician/Me	in the past 12 months?	4□ Pregnan	t at time of death 5	□Ectopic pregna □ Other (specify			Mont	
0	that the di ed by the detached	hys	9 🗆 Unknown	9□ Unknow	n					
ر. ص	The law requires that the te has been signed by th vage 2 should be detache	by P	Part II. Other significant conditions co			underlying cause	given in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
ğ	w require been sig should b	edi	Parkinson	5 D	ISELSE			10'	Yes 2 No 3	☐ Probably 4 ☐ Unknown
Records,	law requas been 2 should	plet						24a. Was	an 24b. We	ere autopsy findings available
R	The lav ate has page 2:	Completed						autor perfo	osy pri irmed? de	or to completion of cause of ath?
		0	25. Was case referred to medical				26 Place o	1 ☐ Yes of Death (Check only of		Yes 2 No
		0	examiner? 1 ☐ Yes _2X No	lospital:	atient 2 ER/Outpatio	ent 3 DOA	Othor	ing Home 5 Resid		(Consite)
	g Physicarthis	T:U	27. Manner of Death	28a. Date of I	njury 28b. Time	of 28c. I	njury at		now injury occurred	
0	Attending I or death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOTHIT,	Day Year) Injury		Work? 1 ⊟ Yes 2 ⊟ No			
Division	l or Attendate death Director:	il lic	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, offi	ice	28f. Location (Street and Number	or Rural Route Number,
Ö	ospital or A hours after uneral Dire ly filled in b	Certification:	4 🗆 Hornieda	building,	etc. (Specify)			City or Tov	vn, State)	
	Hospital 24 hours Funeral tely filled		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the be	est of my knowledge, dea	th occurred at the	e time, date and	place, and due to the	cause(s) and manr	ner as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	one)	and manner	s of examination and/or i stated.	nvestigation, in m	ny opinion, death	occurred at the time,	date and place, an	d due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	2		29c. Lic	ense number		29d. Date signed (Month, Day, Year)
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	6		1 1		of death (Item 23a) (Type	, Print) 4			1.5	
100	Sto		On a than Forma 31. Date filed (Month, Day, Year)	32 .egi	14069 5,0 strar's Signature	rain	204 9 K	an Burhie	My 2	1061
	Sta Registr	_		105	we Is A	as well				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Fime of Death **Physician** ALVIN BROCKINGTON Day Year 6:10 AM APRIL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR HOSPITAL CENTER BALTIMORE, MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Funeral 6 Sax 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) 1**∑** M 2 ☐ F 72 218-28-9237 Director 1 - 4 - 33Md. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show The Medical Examiner must be notified at Completed by Funeral Director Md. 1 ☑ Yes 2 ☐ No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 335 Wellham Avenue 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itam 27 is markad othar than ' Elementary/Secondary (0-12) College (1-4or 5+) 4th grade Disabled NA othar traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Nathaniel Brockington 2 Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine M. Kimble Sister 335 Wellham Avenue, Glen Burnie, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages of Popartment of Himportant: If its any injury or of once. cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cem. 4-15-05 `4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21215 March F.H. West enero 4300 Wabash Ave 23a. Part 1. Enter the disease, or como nations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death One week Immediate Cause (Final Physician PNELLMONIA resulting in death) /Medical Due to (or as a consequence of) Examiner PULMONARY FIBROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit SEMENTIA Due to (or as a consequence of): Box 68760. Physiclan/Medical YEAR! IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. HIZOPHRENIA 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autoosy performed 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No Minimpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funaral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P18437BPQA APRIL 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHALLATI, 3001 St. HANOVER STREET, BALTIMORE, MD, 21225 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 1 4 2005

			State of M			artment of H		•		-egible.	
		For State Registrar	Otato or m	ai y iu	·	rtificate of		Wichtarry	Reg. No.	2005	12677
		1. Decedent's Name (First, Middle, La	st)	_				2. Date of De	eath		3. Time of Death
Physiciai /Medica		Mozella		13	road	on		March	Day 30	Year 2005	7:20 AM
Examine		4a. Facility Name (If not institution, give	h h .		3	4b. City, Town, or	r Location of Dea	ath	4c. (County of Death	1
		5. Social Security Number 6.5			for a high story	If Under 1 Year	Jumb If Under 24 Hr				iard
Funeral Director			7. Ag	e (in yrs	. last birthday) Yrs.	Months Days	Hours Mir		rth ay, Year) 1025	Cou	nplace (State or Foreign untry)
Q		Usual Residence of Decedent		, ,				may 29	, 1743	Sout	h Carolina
arytar show	١	10a. State 10b. County		10c. C	ity, Town or Lo						10d. Inside City Limits
the M	Directo	Maryland Howard 10e. Street and Number		L	Colum			· · · · · · · · · · · · · · · · · · ·			1 ☐ Yes 2 ☑ No
with March	בֿ	5451 Wildwind	D1200			10f. Zip Code 2104	E		_	en of What Cou	untry?
death	Funeral	11. Marital Status	12. Was Decedent	Ever in t	J.S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No		U.S.A. 4. Race - Amer	ican Indian,
after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No		If Yes, specify Cuba 1 ☐ Yes 21⁄2 No		rto Rican, etc.)		Black, White	e, etc.
	d by	3 Widowed 4 □ Divorced	Year or Dates:				Specify:		, ,	Specify: B.	lack
	Completed	15. Decedent's E (Specify only highest gra			16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wi	orking	16b. Kin	d of Business/li	ndustry
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be filed tal Hygin d other event.	ne C	17. Father's Name (First, Middle, Last)		_ <u></u>			ame (First, Middle			-0
Vlar buld b Menta arked atice	0	William Chishol	n				Sara B	eatty			
and and sand sand		19a. Informant's Name/Relationship (ng Address (Street					
e, M	-	Phyllis Nicholls 20a. Method of Disposition	(Daughte		_	Wildwind	Place	Columb:		aryland	
Baltimore, sermit. Pages 1 at Department of Hea mportant: If flem miny injury or othe since.		1 ☑ Burial 2 ☐ Cremation 3 ☐		Ca	cemetery, crei	natory or other plac n Nationa	e)			ation - City or T	
Baltim Permit. Pag Department Important: Inportant: once.	ı	4 □ Donation 5 □ Other (Special21. Signatur Funeral Service Lice		Ce		. Name and Addres		-2005	Calv	erton,	New York
Balt permit. Departr imports any inji		Malle	No129)	¥	itzke Fun 555 Twin	eral Ho	nes, Inc.	ih i	o Monre	land 21045
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the dea						a, Maly	Approximate Interval Between
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/Medical Examiner		resulting in death)	a Due to (or as	a conse	quence of):	JC10 one	rieco	N XU	~		sours
5 6		Sequentially list conditions,	b	-							
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760, A see executed sician and burial-transit	Ya	that initiated events resulting in death) Last	c. Due to (or as	a conse	quence of):						
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68 rtifical rtifical as th											
P.O. Box 6876 nat the death certificate b d by the attending physic letached for use as the b Physician/Medica		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy			23	3d. Date of deliv	,
O. B. D. B.	2	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of	death 5	Other (specify)				Month	Day Year
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f Vital Re system: The system: The sister that director, page	U	25. Was case referred to medical					26. Place of De	1 ☐ Yes eath (Check only o	2 (2/4 0)	1 🗆 Yes	2 L No
Of V Physic rthis ce ral direc)	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatien	t 3 DOA Othe	ar: 4 ☐ Nursing I	Home 5 ☐ Resid	dence 🤚	Other (Specia	ASSISKU
on of oling Ph. After thi funeral	5	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui (Month, Day		28b. Time of Injury	28c. Injury Work	:?	28d. Describe h	now injury	occurred	2011.7
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Divisit To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the Medical Certificat		4 Homicide determined	28e. Place of Inju- building, etc	. (Speci	fy)	eet, factory, office		City or Tox		Number or Rura	al Route Number,
To the Hospital Multin 24 hours & To the Funeral I completely filled Medical Ce		29a. Certifier 1 Certifying Ph	ysician: To the best	f my kn	owledge, death	occurred at the tim	e. date and place	e and due to the	cause(s) a	nd manner as s	tated
he Hosp in 24 hou he Fune pletely fil	2	(Check only 2 Medicel Examone)	niner: On the basis of and manner sta	examina	ation and/or inv	restigation, in my op	inion, death occ	urred at the time,	date and p	lace, and due to	the cause(s)
To the within 2 To the complet		29b. Signature and title of certifier)		29c. License			29d. Date	signed (Month,	Day, Year)
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		30. Name and address of person who	completed cause of d	ath (Iter	m 23a) (Type,	Print)		3 .4	, 1	0 :	MD ZIZZS
Ctoto		31. Date filed (Month, Day, Year)	32. Registra	r's Son	IGM MOV	ncis lane	She L	- 15r00	hlyn	Yarh,	LISTZ ME
State Registrar		À DD		6	A	Carle	,				

Description of Death Service (1997) Service (1 - For State Registrar 1. Decedent's Name (First, Middle of the control of the	(le, Last)		rtificate of L		2. Date of De	Reg. No. 0	5 2 5 3. Time of Dea
Date Rendering of Decoder Deco	/Medical	Merry Me	on, give street and number	<u> </u>		Unine	Month	4c. County of N	Death
1		213 76 0776					8. Date of Bir (Month, Da AUG • 2	4, 1959 M	Birthplace (State or Fo Country) ARYLAND
1 28 194 2 Cremation 3 Removal from Steps TRINITY CEMETERS APRIL 20, 2005 BALTIMORE, MAR 4 Monation 5 Ghard (Specify) 2 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL H 24 Monation 5 Ghard (Specify) 2 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL H 24 Monation 24 Monation 25 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL H 24 Monation 24 Monation 25 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL H 24 Monation 24 Monation 25 Mon	28a-1 show culfied at							10- 02	10d. Inside City Li
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1 28 24 2 Cremation 3 Permoval from Policy 1 2 2 2 2 2 2 2 2 2	narked oth natic evan To Be	17. Father's Name (First, Middle, RONALD E. BLACK	KLEDGE	22. 14. 10		CYNTHIA N	MOODY		
23. Part I. Erre the disease, or complications that caused Me offsh. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23. Part I. Erre the disease, or complications that caused Me offsh. Do not enter the mode of dying, such as cardiac or respiratory arrest. 24. Immediate Cause (final present of the disease). 25. Clause (final present of the disease). 26. Place of the disease of the	C	KATRINA BLACKLE 20a. Method of Disposition 1 XBurlal 2 Cremation 4 Donation 5 Other (S	EDGE (SISTER	R) 3027 20b. Place of Disport Commetery, creating TRINITY C	W. GARRIS estion (Name of matory or other place EMETERY	ON AVE. F	BALTIMOI Pate 20, 20	RE MARYLA 20c. Location - City 005 BALTIN	AND 21215 or Town, State MORE, MARYI
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(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	this certificate has been signed by the attending to director, page 2 should be detached for use as director, page 2 should be detached for use as To Be Completed by Physician/Mer	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant 9 Unknown ons contributing to death Hospital: 28a. Date of Ir (Month, E	2 Fetal death 3 at time of death 5 b	t 3 DOA Other	26. Place of Death 4 □ Nursing Hon at 2	24a. Was a autop perfor 1 Yes (Check only or ne 5 Resid	Month bacco use contribut es 2 No 3 an 24b. Were prior deat No 1	delivery Day Year to the cause of death Probably 4 Unkn autopsy findings avail to completion of cause Yes 2 No
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. NAZ-ARIAN, Mp 301 ST PAUL ST BALTMORS	Furnals alreadors when this certificate has been signed by the attending rely filled in by the funeral director, page 2 should be detached for use as call Certification; To Be Completed by Physician/Merical	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant 9 Unknown ons contributing to death Hospital: 1 Pregnant 1 Pregnant 28a. Date of Ir (Month, Live) 28a. Place of Ir building, 1 Physician: To the bes Examiner: On the basis and manner	2 Fetal death 3 at time of death 5 at time of linjury 2 at time of linjury 2 at tof my knowledge, death of examination and/or invisated.	t 3 DOA Other 28c. Injury Work' M 1 Y eet, factory, office	26. Place of Death 4 \(\triangle \	24a. Was a autop performed to the control of the co	Month bacco use contribut es 2 No 3 an yellow ye	delivery Day Year e to the cause of death 1 Probably 4 Unkn a autopsy findings avail to completion of cause ? fes 2 No Specify) Fural Route Number, tras stated. due to the cause(s)

DHMH 17 Rev 1/2001

ORIGINAL

	State of Maryland / Department of Health and Mental Hygiene 1- State State Registrar Certificate of Death Reg. No. 2015 2679											
	Physici		1. Decedent's Name (First, Middle, Last)			BR	OWN	2. Date of De.	ath Day	Year 2005	3. Time of Death	
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s The Johns Hoff 5. Social Security Number 6. Sex	TINSHOSPH	ast birthday) Yrs.	4b. City, Town, o City Town, o Git Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Jan. 1	h y, Year)	ounty of Death N/A 9. Birthp	place (State or Foreign	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic event, the Medical Examination in Item Political at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Balti	, Town or Loo	m or Location			10d. Inside City Limits 1 □ Yes 2 ◯XNo				
			10e. Street and Number 2048 Larkhall RC 11. Marital Status 1 □ Never Married 2 ☑ Married	oad 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 1 No	S. 13. W	1	21222 ispanic Origin? (Sp In, Mexican, Puerto		Unit	en of What Cour ced Stat . Race · Americ Black, White,	CES can Indian,	
			15. Decedent's Education (Specify only highest grade completed) (Give kind of wo			ent's Usual Occup	sual Occupation 16			Specify: White Sb. Kind of Business/Industry		
			17. Father's Name (First, Middle, Last) William Sprole	2 Years		Nurse	18. Mother's Nam		Maiden Si		re Provider	
ď.			19a. Informant's Name/Relationship (Ty) Mr. Lawrence F. 20a. Method of Disposition	Brown (Husband) 204 ace of Dispos	8 Larkha		a <i>l Route Numbe</i> Dundalk Date	, Mar		21222	
Baltimore,	permit. Pages I Department of H Important: If ite any injury or ot		1 ☐ Burial 2 【Cremation 3 ☐ R Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligense	Hi	lltop 22. Du	Name and Address da-Ruck	Corp. 4/1 ss of Facility Funeral H	Home of	Tov Dunda	vson, Ma	aryland	
	or Attending Physician: The law requires that the death certificate be executed the death. If the death. Director: After this certificate has been signed by the attending physician and much properties that the funeral director, page 2 should be detached for use as the burial-transit and the land.	i Certification; To Be Completed by Physician/Medical Examiner	23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in Immediate Cause (Final							Approximate Interval Between Onset and Death Weeks		
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			25. Was case referred to medical		26. Place of Death (t			1 ☐ Yes	opsy prior to completion of cause of death? 12 No 1 Yes 2 No		npletion of cause of	
			27. Manner of Death Natural 5 Pending investigation		P/Outpatient 28b. Time of Injury	28c. Injury Work	er: 4 Nursing Ho		ence 6)	
Division			3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) sician: To the best of my knowledge, death occurred at the time, date and place,		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital within 24 hours a To the Funeral Completely filled	ledicai	(Check only 2 Medical Examin	ician: To the best of my knowner: On the basis of examination and manner stated.	on and/or inve	estigation, in my or	pinion, death occurr	ed at the time, o	late and pl	ace, and due to	the cause(s)	
)	To To	W	29b. Signature and title of certifier Crusture E. B	9			number			7, 2005	Day, Year)	
	15		30. Name and address of person who cor CRISTINE E. BERRY, JO	the Hobkins Hos	PITAL,	TOWER IN	poctor's Lo	unge, 60	NORTH	H WOLFE !	TREET	
	Sta Registr	te	31. Date filed (Month, Day, Year) APR 1 4 2	32. Redistrar's Signatu	K A	baste						

			State of Maryla 1- State Registrar AMEND ITEM #16b PER FH (nd / Department of Health and				
	Physic	an.	Decedent's Name (First, Middle, Last)	5 0-25 - KITAPUS USID CUIT	2. Date of Death	No. 3. Tigrie of Death Day Year		
	Physic /Medi	cal	NORMA RAY BARGER	April	2005 5:27PM			
	Examir	ier	4a. Facility Name (If not institution, give street and number) Novth Avundal Hospital	4b. City, Town, or Location of De	ath O	4c. County of Death Annu Arundel		
	Funeral	0		s. last birthday) If Under 1 Year If Under 24 H		9. Birthplace (State or Foreign		
	Director		Usual Residence of Decedent	Yrs.		1928 ОН		
	show	<u>_</u>		City, Town or Location		10d. Inside City Limits		
	r 28a-1 show	Director	MD ANNE ARUNDEL GI	LEN BURNIE	100	1 ☐ Yes 2X No Citizen of What Country?		
	th with 23a or		901 PRINCETON TERRACE	21060		ISA		
	tems termi	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?			14. Race - American Indian, Black, White, etc.		
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-1 show marked ovent, the Medical Examiner must be notified u	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ŽNo Specify:		Specify: WHITE		
21215-0036	72 hol	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of w	rorkina 16b.	. Kind of Business/Industry		
121	within 72 lene. than "nat	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired) HOMEMAKER		OWN HOME IOMEMAKE R		
and	be filed tal Hygie d other event,	BeC	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maid			
<u>Z</u>	should be and Mental is marked of sumatic even	2	CHARLES EDWIN LANNING	ALMA TU				
Mary	d 2 d in ar 7 is trau		19a. Informant's Name/Relationship (Type, Print) GREG BARGER / SON	19b. Mailing Address (Street and Number or 1652 TANGLEWOOD DRIVE		y or Town, State, Zip Code) S, MD 21784		
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr.		20a. Method of Disposition 20b. 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or Town, State		
tim	t. Pag rtment rtant: I njury o		`4 ☐Donation 5 ☐ Other (Specify) ARI	LINGTON NATIONAL 04.	/21/2005 _{FOR}	T MYER, VA		
Bal	permit. Departiumport any inj		21. Signatore of Funeral Service Licensee	22. Name and Address of Facility SINGLETON FUNERAL		SECOND AVE. S.W. EN BURNIE, MD 21061		
×,			23a. Part1. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line.	th. Do not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	the shock		Oriset and Death		
	Examiner			querice ory.				
1	bed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):				
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68760	tificate be executed ig physician and as the burial-transit	edical	d					
Вох 6		n/Me	IF FEMALE: 23c. If yes, outcome of pregnant			23d. Date of delivery		
.O. B	requires that the death cer een signed by the attendin hould be detached for use	Physician/M	in the past 12 months? 1 Yes 2 100 9 Unknown			Month Day Year		
4	es that tigned by	by Ph	Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?		
Records,	w require been sig should b		Renal failure	1 🗆 Yes	s 2 No 3 Probably 4 Conknown			
Sec	elaw has b	Completed	0	24a. Was an autopsy performed?	autopsy prior to completion of cause of			
Vital	ng Physician: fter this certific ineral director,	0	25. Was case referred to medical	26 Place of De	1 Yes 2 1 Neath (Check only one)			
of Vi		Certification: To Bo	6 ☐ Other (Specify)					
			27. Manper of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time of lnjury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	28d. Describe how injury occurred		
Division	Attending or death. ector: After by the fune		2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At houlding, etc. (Special Coulding Coulding Special Could	28f. Location (Street	ion (Street and Number or Rural Route Number,			
Ö	oital or urs afte ral Dir iled in				City or Town, Sta			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phys/Gian: To the best of my kni (Check only one) 2 ☐ Medical Exeminer: On the basis/of examin. and manye/stated.	owledge, death occurred at the time, date and place ation and/or investigation, in my opinion, death occ	e, and due to the cause(curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)		
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)		
		ļ	1/1/2009	21940		4.4.07		
	10		30. Name and address of person who completed cause of death (Itel	-) North Aru	ndel	Rospital		
8) - 150	Sta Registr	100	31. Date filed (Month, Day, Year) 32. gistrar's Sign.	ature Anada				

State of Maryland / Department of Health and Mental Hygiene 1- Stote Amend Item 20a-c&22 per fh G862erfifil 2005 per th 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2005 **Physician** March 17, 6:11 PM M Edward Beard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 20141 Point Look Out Road #3 Great Mills St. Mary's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth Feb 9, 1948 Birthplace (State or Foreign Country)
 unk 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 ☐ F 57 213-52-7376 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Great Mills St. Mary's Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20141 Pt. Look Out Road #3 20634 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. unk. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: black ð 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ODEs. Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Md State Police/Trpr Quaid 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Carroll Cremation 4-14-05 5 Other (Specify) in state Hampstead, MD State Anatomy Board 655 W. Baltimore Screet Baltimore, ND 21201 11824 Reisterstown Road 21. Signature of Everal Service Licensee Ronald S. Wayte 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory stown, MD 245436 ate shock, or heart failure. List only one cause on each line. Onset and Death CARDIOMYOPATHY Immediate Cause (Final disease or condition resulting in death) Physician YEARLI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exam the attending physicien and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by MERTEN STOW 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 11No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D56096 4.5.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RATISIN DER S. GILL 24635, TIMEE NOTCH, HOW YWOOD, MD 20036 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2005 Registrar

			1- State of Marylar Registrar		rtment of He tificate of D		nd Mental Hy	giene,	11115	1268	2
ı	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Do Month	Day	Year	3. Time of Death	
	/Medic Examin		Shannon M. Blair 4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or i	Location of	APRIL	05 ,	2005 County of Death	10:200	М
	LXdIIII	ici	N/B ROUTE 4 RAMP at N/B ROUTE 3	01	UPPER MA				INCE GE		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bi Min. (Month, D. June 2	th	9. Birth	oplace (State or Fore	ign
	Director	•	217-98-9591 ** 36 Usual Residence of Decedent	, TIS.			June 2	1 19	og D	.ć.	_
	uryland show	_	10a. State 10b. County 10c. Ci	ty, Town or Loc	cation					10d. Inside City Limi	
	he Ma 28a-f e	Director		Spring						1 ☐ Yes 2 ☐ N	40
	with t	DI	10e. Street and Number 9406 Carol Street		10f. Zip Code 2077	1		10g. Citiz	en of What Cou	untry?	
	hours after death with the Maryland tural', or Items 23a or 28a-f ehow I Erstiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?		Vas Decedent of His	panic Orig	in? (Specify Yes or N)- 1·	4. Race - Amer	ican Indian,	
36	s after	by Fu	XXNever Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give		Yes, specify Cuban Yes 2010	Specify:	Puerto Rican, etc.)		Black, White Specify: B1		
Ş	2 hour	ed b	3 Widowed 4 Divorced Year or Dates:	16a, Deced	ent's Usual Occupat	ion			d of Business/l		
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7	be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or liems 23a or 28a-f ehow event, the Medical Ers citrer must be notified at		12th 0	Come	rical Ar				f Empl	oyed	
and	d be finding H	Be c	17. Father's Name (First, Middle, Last) Marshall G. Blair				's Name <i>(First, Middle</i> irley Bl		Sumame)		
Maryland 21215-0036	should by and Menta s marked umatic ev	J.	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street ar		or Rural Route Numb		Town, State, Z	ip Code)	
	and 2 salth a n 27 is		Marshall G. Blair (Father)	70777777777774	5 m Caro		. Spring				
ore	of He		20a. Method of Disposition 20b. F	Place of Dispos	sition (Name of atory or other place)		Date		ation - City or T		
Baltimore,	G 5 2 2		'4 □Donation 5 □Other (Specify) Met		ematory			alt:	imore,	Md.	
Ra	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee Zarry B. Leese MO0483		Name and Address Reese		ons Morti	io.ry	P.A.		
	1 48		23a. Part1. Enter thi disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not ente	ZI_WEST or the mode of dying,	St. such as c	Annapoli: ardiac or respiratory a	rrest,	1. 214	Approximate	
	Physician			TIPL	E INJ	Uni	Es			Interval Between Onset and Death	
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Ď,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a conseq	uence of):							
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XOX	leath certific attending p I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23	d. Date of deliv	/erv	
ň	death ne atten ed for u	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other (specify)				Month	Day Year	
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gs,	signe d be d	d by	Part II. Other significant conditions contributing to death but not res	uiting in the un	derlying cause giver	ın Parti.	23e. Dia 1	_		the cause of death? bably 4 □Unknow	n.
ecords	faw requas been 2 shoul	ompieted					24a. Was	/		opsy findings availab	
r	0 4 9	шо					auto	rmed?	prior to co	ompletion of cause of	
VII	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?			26. Place o	of Death (Check only o		7083	20140	_
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	ling After fune	tion	27. Manner of Death 1 □Natural 5 □ Pending 2 ☑ Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 🗆 Ye		10 - 10			RUCK FIXE	
JIVISION	Attendi er death. ector: A by the fu	ertification;	3 Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specific Could form the building).	ome, farm, stre			06	Street and	Number or Rur	al Route Number	u
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	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the I	edicai	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examina and manner state.	wledge, death tion and/or inve	occurred at the time estigation, in my opin	, date and nion, death	place, and due to the occurred at the time,	cause(s) a	nd manner as	stated. to the cause(s)	
	ro the within : Fo the comple	Mec	one) and manner stated. 29b. Signature and fill pof certifier		29c. License	number		29d. Date	signed (Month,	Day, Year)	
	. 25 3		1/// // /n	\rightarrow	OCME			APRIL	06, 2	2005	
	1		30. Name and address of person who completed cause of peath (Item	23a) (Type, F		- C+	D-7:		M - 7	. 1 01001	
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			1 - For State Registrar	State of Ma	ryland		artment tificate			and Me		giene	6	05	1268
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	er						1	2. Date of De. Month	ath Day	y ₃	Year 05	3. Time of Death
	Exami		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location o	of Death		4c.	County	of Death	7007
			Anne Arundel Me					apo.		0411			nne	Arur	
	Funeral Director		5. Social Security Number 214-46-0513 Usual Residence of Decedent	M 2 F	(In yrs. las	Yrs.	If Under Months	Days	If Under a	Adin	B. Date of Bird (Month, Pa	th y, Year)	946		ace (State or Foreign try) "land
	yland now		10a. State 10b. County		10c. City,	Town or Lo	cation			·	-			10	Od. Inside City Limits
	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show he Medical Examinar wat be multired at	Funeral Director	Maryland Anne Ar	undel	Ann	apol	1 S	Code			T	10g Cit	izen of V	Vhat Coun	MCXYes 2 □ No
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/lan		To B	Leon	Butler							ta Hu				
Mar			19a. Informant's Name/Relationship (Type												Code) 21401
	1 and 2 Health em 27 i	1	Cornelia Butler 20a. Method of Disposition	(Wife)	20b. Plac	e of Dispo	sition (Nam	e of	- TT	n St.				nnap	olis, Md
ē	o		1 ☐ Burial 2 ②Cremation 3 ☐ Ro `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cem	ietery, cren	ratory or oti remail	her place		4/12/	05			ore,	
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service License	4. 4.4		22	. Name and	Address	of Facility	Sons	MOrt	cuar		P.A.	
			23a. Part1. Enter the disease, or complic	ations that caused t	he death.	Do not ente	821 Ter the mode	Vest of dying	St., such as o	Anr	apoli espiratory ar	rest,	Md.		Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line		C	ungc	ance	r						Interval Between Onset and Death
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rds,	The law requires that the stee has been signed by the page 2 should be detache.	ed by	Part II. Other significant conditions conf	nbuting to death but	not resultir	ng in the un	derlying ca	use giver	n in Part I.						e cause of death?
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ta 		e Co	25. Was case referred to medical						OC Plans	of Donah //	1 ☐ Yes	2 No			P□ No
Ţ	Physicien: r this certific ral director,	To B	examiner?	ospital:	2 🗆 ER	/Outpatient	3 ☐ DOA	Other			Check only or 5 ☐ Resid		3 □Othe	or (Specify)	
Division of Vital Records,	nding Pł tth. : After the funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day	Year) 28	b. Time of Injury	28 M	c. Injury a Work?		280	d. Describe h				
Divis	l or Attend after death Director: /	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home (Specify)	, farm, stre	et, factory,	office		28f	Location (S City or Tow	itreet and n, State)	d Numbe	or Rural	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death within 24 hours after death or To the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	cian: To the best of er: On the basis of e and manner state	xamınatıon	dge, death and/or inv	occurred a	t the time	, date and nion, death	place, and	d due to the cat the time, d	ause(s)	and mar	nner as sta	ted. he cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier	r.			29c.	License			2			(Month, D	ay, Year)
)			,	Beck, My				_	6052				13(5	
	1		30. Name and address of person who con	repleted cause of dea	th (Item 23	Ba) (Type F	Print) Pa	rikw	'ey j	anna	yours, l	Mo			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	H A	porte								

				artment of Health and Mental Fertificate of Death	lygiene Reg. No. 0 0	5 12686
	Dhomis		Decedent's Name (First, Middle, Last)	2. Date of	Death	3. Time of Death
	Physici /Medio		Irene D. Cornell	Apri Apri	$111^{\text{Day}}, 200$	5 4:10 A.M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of	Death
			Ridgeway Manor Nursing Home	Catonsville		imore
	Funeral Director		5. Social Security Number 212-20-3667 Usual Residence of Decedent 6. Sex 1 M 2 To F 7. Age (In yrs. last birthday 7. Age (In	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. Jan.	Birth <i>Day</i> , Year) 18, 1924 1	Birthplace (State or Foreign Country) Maryland
	/land		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	Man f sh	tor	Maryland Baltimore Woodl	awn		1 ☐ Yes 2 🛣 No
	or 286	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?
	23a c	aiD	5536 Clifton Avenue	21207	USA	
	tems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race -	American Indian, White, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other treumetic event. It Medical East Latriust be notified at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖫 No Specify:	Specify:	White
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	filed v Hygie ther t	ပိ	12 Stat	e Clerk 18. Mother's Name (First, Mid.	State of	Maryland
an	d be ental ced o	To Be	Joseph Dobos	Ida Paula Fea	-/	
Maryland	shoul nd M mar	F		ing Address (Street and Number or Rural Route Num		te Zin Code)
	alth a 27 is			Clifton Avenue; Woodla		
ore,	of He of He item		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date matory or other place)	20c. Location - Cit	y or Town, State
Ē	Page nent ent: If ury or		1 Burial 2 Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Lorraine	1	Woodlawn	Maryland
Baltimore,	permit. Departe Importe any inj		VS (It I W)	2. Name and Address of Facility Sterling Ashton Schwab	Funeral H	ome. Inc
			23a, Part1. Enter the disease, or complications that caused the death. Do not ex	736 Edmondson Avenue; ter the mode of dying, such as cardiac or respirator	Catonsvill	e, MD 21228 Approximate
	enysician :		Immediate Cause (Final			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	HEAR MAILUI	20	6 MOS
	Examiner		Sequentially list conditions b. COKANART	HEART DISEASE	-	10 4KS
<i>L</i> .	P #	iner	ff any, leading to immediate Due to (or as a consequence of).			
60	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
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687	ficate phys s the	edicai	d			
X	death certifi e attending p od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
.O. Box	0 00	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	Month	Day Year
o.	by the a	hys	9 ☐ Unknown			
	gned good	by F	Part II. Other significant conditions contributing to death but not resulting in the t	nderlying cause given in Part I. 23e. Di	d tobacco use contribut	te to the cause of death?
Records,	w require		CYNPHOMA	1]Yes 2. ZNo 3. □	Probably 4 Unknown
Ö	taw taw tas be	Completed		24a. W	as an 24b. Were prior	autopsy findings available to completion of cause of
_	: The tay cate has	Co		pe 1 ☐ Yes	normed deat	h? Yes 2∐ No
<u>≅</u>	iicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death /Check onl		
ō	Phys r this ral di	- To	1		sidence 6 Other (8	Specify)
O	nding th. : Afte	tion	1 ✓ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No	e now injury occurred	
Division of Vital	Atter r dea ector by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st	reet, factory, office 28f. Location	(Street and Number o	r Rural Route Number.
Ā	tel or Attendi s after death. el Director: A ed in by the fu	Certification:	4 ☐ Homicide determined building, etc. (Specify)		own, State)	,
1	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director, to	Medicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the tim-	e, date and place, and	due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)
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	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) SYII O-D MIC	oon.ex	08,8
	- 1		CHUSTING a COMMERCINO	30 parnoce	, MD 71	225
	Stat Registra		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Charles 2007) 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 4 2005	H. Sparke		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Mary Virginia Blankenship Cramer April 13 2005 3:58 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lorien Columbia Nursing Home Columbia Howard If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 12,1917 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 230-26-9130 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Ia marked othar than "natural", or Itams 23a or 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic evant, the Medical Exercitive must be notified at Maryland Howard 1 Yes 2X No Directo Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9449 Pursuit Court 21045 U.S.A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teaching Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Blankenship Ida Mimms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Ia any injury or other trau <u>once</u>. Bryson M. Cramer (Son) 9449 Pursuit Court Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Forest Lawn Cemetery | 4-16-2005 Richmond, Virginia 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Physician accident. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 1 ☐ Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a a Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI) 13 6)

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	Funeral Director		Social Security Number 6. 5		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Jan 29	Year) 35 Ma	thplace (State or Foreign ountry) rvland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
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	death with the Maryland ims 23a or 28a-f show r man be notified at	Funeral Director	10e. Street and Number 3509 Milford	Mill Rd		10f. Zip Code 2 1 2	244	1	U.S.A.	ountry?
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of the reaumatic event, the Medical Exacting from the multified at ODE.	by Funer	11. Marital Status 1 X Mever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 XXVo If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes XIXNo	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
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	pu k		Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or Lo	cation							100	I. Inside Cit	y Limits
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	ems 2	ner	11. Marital Status	12. Was De	cedent Forces?		3. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - Ar Black, W			
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturelt, or Items 23e or 28e-1 show mit injury or other treumatic event, Its Macical Examinet must be notified at once.		21. Signature of Furieral Sovice			010	D22	2. Name ar	d Addres	s of Facilit	y Ro	west A. 2085	Pun	nphrey	Fun	eral	Home,
ŏ	Department Department Important Important Information		MarilE	: Bu	4.	M008	303 R	ockvi.	11e,	Mary	1and	2085	50-2	805	1100		
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that	t cause each li	d the death ine.	Do not ent	The	le of dying	g, such as	cardiac	or respiratory a	ırrest,		1 1	Approximate nterval Betwood	ween
7 ,00,00	Certificate be executed and rding physician and see as the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	o (or as	s a conseques a conseques a conseques a conseques sa consequences	uence of):	ac	Ja	mp	lu	la					
.O. BOX	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 STO		e birth gnant a	of pregna 2 Fetal at time of de	death 3[∃Ectopic p						23d. Date of Month	,		ear ear
coras, r	requires that the de ben signed by the a hould be detached f	by	Part II. Other significant condition	ons contributing to						en in Part I				use contribute		cause of do	
Ŭ L	has the	Completed	Syndrover (Sypathy)	u. Pac	ni	. An	in h	ype ev/c	pin	ude	ur	24a. Was auto perfe	psy ormed?/	prior death	to com	sy findings a pletion of ca	available ause of
VII	ysicien: Th is certificate director, pag	Bec	25. Was case referred to pedica examiner?					0			of Deal	h (Check only	one)				
0	Physicien: r this certific ral director,	^o L	1 ☐ Yes 2 ☐ No		Inpati		ER/Outpatie			4 E N	ursing Ho	ome 5 Res			pecify)		
	fte	lon;	27. Manner of Death 1 Natural 5 ☐ Pendir	ig .	onth, Da	ay Year)	28b. Time o Injury	M	28c. Injun Worl	yat k? Yes 2□	No.	28d. Describe	now inju	ury occurred			
JIVISION	or Attending after death. Director: After in by the fune	Certification;	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Pla		jury - At ho tc. (Specify	ome, farm, st			100 2		28f. Location (City or To			Rural	Route Numi	ber,
-	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Ce	29a. Certifier 1 Certifyir (Check only one)	ng Physicien: To Exeminer: On the and m	the best basis (of examina	wledge, deat tion and/or in	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(date ar	s) and manner nd place, and c	as sta	ted. he cause(s)
	o the	Мес						29	c. Licens	e number			29d. D.	ate signed (M	onth, D	ay, Year)	
	- 5 h û		14 Rapert	Dusie	he	lear	ans		00.	4113	5		4p	ril 12	12	205	ark.
	(0		29b. Signature and title of certifie ARAGE 30. Name and address of person AROBERT 31. Date filed (Month, Day, Year	who completed co	ause of	death (Item	2 (Type	, Print) Z	011	EUS, 748,	S E C CSB	LAVE, n	20	208.	77		
	Sta Regist		31. Date filed (Month, Day, Year,	4 2005	. F gist	trar's Signa	turk A	book)								

			. 101	tment of Health and Mental Hygien ficate of Death	4000 12009
			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physicia /Medic		Phillip T. Collins	April 1 2	2005 Yeer 2248 M
	Examin		4a. Facility Name (If not institution, give street and number)	b. City, Town, or Location of Death 4d	c. County of Death
				Annapolis If Under 1 Year If Under 24 Hrs. 8, Date of Birth	nne Arundel
	Funeral Director		1⊠M 2□F 01 Vrs	Jonths Days Hours Min (Month, Day, Year,	9. Birthplace (State or Foreign Country) 1923 Maryland
			Usual Residence of Decedent		1929 Haryland
	arylan show		10a. State 10b. County 10c. City, Town or Local	ion	10d. Inside City Limits
	Ba-f s	ecto	Maryland Anne Arundel Edgewate		1 ☑ Yes 2 ☐ No
	a or 2	by Funeral Directo	10e. Street and Number		itizen of What Country?
	leath	eral	4129 Old Muddy Creek Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	21037 s Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian,
0	or itan	Fun	Armed Forces? If 1 □ Never Married 2 ☑ Married 1 □ ☑ Yes 2 □ No	s Decedent of Hispanic Origin? (Specify Yes or No- es, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
8	filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or Itams 23a or 28a-f show itht, the Medical Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1943-45	Yes 22 No Specify:	Specify: Black
215-0036	"natu	Completed	(Specify only highest grade completed) (Give ki	It's Usual Occupation If of work done during most of working NOT use retired)	Kind of Business/Industry
212	withir ene. than	Juno	Elementary/Secondary (0-12) College (1-4or 5+)	Ann	e Arundel Board Education
		e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maider	
Maryland	73 ⊆ 00 (1	To Be	Seymour Collins	Louise Brent	
ar	ss 1 and 2 should of Health and Me Itam 27 ia mark other traumation		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Route Number, City	or Town, State, Zip Code) 21037
	and 2 ealth m 27 in			Old Muddy Creek Rd. Ed	
altimore,	Pages 1 nent of H int: If itar iry or oth		20a. Method of Disposition 1 Berrial 2 Cremation 3 Removal from State Chews UM	on (Name of Date 20c. L	ocation - City or Town, State
Ē			Cemetery Cemetery	4/8/05 _0w	ensville, Md.
ga	permit. Departi Import. any inj once.		21. Signature of Funeral Service Licensee	ame and Address of Facility 1. Reese & Sons MOrtuar 1 West St. Annapolis,	y, P.A.
			23a. Part1. Enter the disease, or complications that caused the dilath. Do not enter		Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	0 0 1	Interval Between Onset and Death
-	/Medical		disease or condition resulting in death) a Due to (or as a consequence of):	an col	10104
	Examiner		Sequentially list conditions b.		
1	P + 10	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):		
	and I-trans	Examiner	Cause (Lisease or injury that initiated events resulting in death) Last		
8/60,	cate be executed hysician and the burial-transit	licai E	355 15 (5) 45 45 45 15 45 15 5 (7)		
89	certificate be executed ding physician and use as the burial-transit		0.		
ROX	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	stopic pregnancy	23d. Date of delivery
	0 0 0	sicia	1 Yes 2 No 4 Pregnant at time of death 5 0	ther (specify)	Month Day Year
J.	that the de ed by the detached	Phy	9 Li Onknown	. D	use contribute to the cause of death?
က်	36 PG	by	Part II. Other significant conditions contributing to death but not resulting in the und	967-1 0	USe contribute to the cause of death?
ecords,	w require been si should b	etec	1 21 6 1000		
He H	The law ste has bage 2 a	Completed	Aylan Com	24a. Was an autopsyy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital		e Co	25. Was case referred to medical	1 ☐ Yes 2 ☐ No. 26. Place of Death (Check only one)	1 Yes 2 No
	Phyalcian: r this certific ral director,	0 8	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	Other: 4 Nursing Home 5 Residence	6 □Other (Specify)
ס ר	aling Phys	T :U	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 28d. Describe how inju	
0	Attanding Phir death. actor: After the	catic	2 Accident investigation	M 1 Yes 2 No	
Division	or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	, factory, office 28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	pital burs a aral [0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	poured at the time, date and place, and due to the appear	and manner or stated
	To the Hospital or Attano within 24 hours after death To tha Funaral Diractor: completely filled in by the	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or inve	tigation, in my opinion, death occurred at the time, date and	d place, and due to the cause(s)
	To the complete compl	Me	29b. Signature and title of certifier	29c. License number 29d. Da	ate signed (Month, Day, Year)
)			10 DOWN	X DOCCHAS S H	14/01
	INT		30. Name and address of person who completed days of death (Item 332) pe, Pr	nt) DK, EK 9 M. IPS-	
	In.		31. Date filed (Month, Day, Year) 32. Renistrar's Signature	214) E (m) 214	01.
	Sta Registra	- 3	31. Date filed (Month, Day, Year) APR 1 4 2005	which is a second of the secon	
_			LILL T T THE PARTY		

			1 - For State Registrar	State of M	laryland / Depa	artment rtificate			and M		20		12600
			1. Decedent's Name (First, Middle, La	st)						2. Date of Dea		UU	3. Time of Death
	Physic /Medi		Willie Foster							April	7, Day 200	Year 5	2:00 PM ^M
}	Exami		4a. Facility Name (If not institution, give			4b. City, To	own, or l	Location o	of Death			ty of Death	1 2700 211
			Southern Maryla	_			ntor				Prin	ce Ge	orge's
п	Funeral		5. Social Security Number 6. S 248-70-3339	ex 7. A ▼ M 2 ☐ F	ge (In yrs. last birthday) 65 Yrs.	If Under 1 Months	Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Day Jan 5,	h v. Year)	9. Birthp	lace (State or Foreign htry) h Carolina
	Director		Usual Residence of Decedent		0.5					Jan 3,	1940	Sout	h Carolina
	ylanc		10a. State 10b. County		10c. City, Town or Lo	cation						1	0d. Inside City Limits
	e Ma	ctor	MD Clinto	n	Prince	Georg	g e' s						1 ☐ Yes 2X No
	ith th	Funeral Director	10e. Street and Number			10f. Zip C	ode				10g. Citizen o	f What Cour	itry?
	s 23e	rai	9211 Stuart Lane				207					USA	
	item item	une	11. Marital Status 1 □ Never Married 2 → Married	12. Was Decedent Armed Forces	?	Was Deceder f Yes, specify	nt of His y Cuban	panic Orig , Mexican	in? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bi	ace - Americ ack, White,	
36	urs aft	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 📉 If Yes, Give Year or Dates:	NO .	1 □ Yes 2 🛚	No D	Specify:			Spec	ity: bla	ck
21215-0036	72 hours after death with the Maryland neturel', or items 23a or 28a-f show dical Examinat must be notified at	ted	15. Decedent's Ed	ucation	16a. Deced	dent's Usual (Occupat	ion			16b. Kind of	Rusiness/Inc	fustor
218	within 7 ene. than "n	Completed	(Specify only highest gra		(Give	kind of work DO NOT use	done du retired)	ıring most	of worki	ng			
	filed with Hygiene. Ithar thai	Con	12	College (1-4or	a	dminis	tra	tive			auto	motiv	e
ğug	be fil	Be	17. Father's Name (First, Middle, Last) George Foster				1	18. Mother	r's Name	(First, Middle,	Maiden Surna	ime)	unk
3	d Ment d Ment narke netic	To											
Maryland	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "neturel", or items 23a or 28a-f show any njury or other freumetic event, the Medical Examiner must be notified at ance.		19a. Informant's Name/Relationship (7) Gwen Foster/spous							l Route Number			
ē,	Health tem 27 other tr		20a. Method of Disposition		20b. Place of Dispo-	sition (Name	of	1		Washin	gton,		
JOL	Pages nent of I int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🕅 Other (Specify	Removal from State	cemetery, cren	natory or othe	er place))			200. Location	- City of 10	wii, Siale
Baltimore,	permit. Pag Depertment Important: I any injury o	. 1	21. Signature of Huneral Service Licen			. Name and	Address	of Facility	,				
m	Depuil Important	ļ. 19	man s	wade, our	1	ate Ar	nato	my Bo	pard	655 W.	Baltin	nore S	treet
	*		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused	d the death. Do not ente	ltimor	of dying,	such as c	ardiac o	r respiratory arr	est,		Approximate
	Pnysician		Immediate Cause (Final disease or condition	Ker	tal by	2A11	nc	7				1	Interval Between Openiand Death
	/Medical		resulting in death)	Due or as	a consequence of):	0	\Rightarrow	5	-				DIV
W.	Examiner	L	Sequentially list conditions.	b. Erd	Maye	160	nia	l	di	seen	L		Morde
	lsit ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as	a consequence of).		1/2	4.	1	- 0 -	1.	7	1 1
•	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to for as	a consequence of):	ue,	Ne	en	1	Jeu	ans	2	- bonh
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9		a)		0		0,00		7	V	FIGUR	o-j		jear
Вох	death certifi e attending p d for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					1		23d. Da	ate of deliver	v
	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at		Ectopic pregr Other (speci							Day Year
P.O	at the de d by the a stached i	Physici	9 Unknown			-							
Ś	The law requires that the te has been signed by thi vage 2 should be detache	by	Part II. Dther significant conditions co	ntributing to death b	ut not resulting in the un	derlying caus	se given	in Part I.			./	tribute to the	a cause of death?
oro	w requir been s should	eted								1 🗆 Ye	s 2 MNo	3 Proba	bly 4 □Unknown
Records,	elaw has b	Completed								24a. Was all autops	V /	prior to com	sy findings available pletion of cause of
										perform 1 ☐ Yes 2	ned?	death? 1 ☐ Yes 2	2□ No
Vital	Physicien: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:	_		Other:			(Check only on	. /		
of		\vdash	1 Yes 2 No 27. May ler of Death	1 Inpatie					7	e 5 Reside			
on	토토토	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year) Injury	М	Injury at Work?	s 2 □ No		DG. Describe NO	w injuty occur	180	
	l or Attendi after death. Director: A lin by the fu	ifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At home, farm, stre	et, factory, of	ffice		2	Bf. Location (Str	reet and Numb	per or Rural	Route Number,
	tel or A rs after el Dire ed in b	Certification:	4 - Homelde	building, etc	с. (Бреспу)				Į,	City or Town	, State)		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Cartifying Phy	sician: To the best of	of my knowledge, death examination and/or invested	occurred at the	he time,	date and	place, a	nd due to the ca	use(s) and ma	anner as sta	ted.
	the hin 24 the F	Medi		and manner sta	ited.				occurre	u at the time, da	ite and place,	and due to t	he cause(s)
	Nit Co.	-	29b. Signature and title of certifier	0 -		29c. Li	cense n	umber	- 20	29	d. Date signe	d (Month, D	ay, Year)
7		-	VIIM	1/		10	- 6	-4>	フノ	>	04,0	8,0	5
			30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Type, P	rint)] ,		1	Linta	a m	1	7070-
	Sta	te	31. Date filed (Month, Day, Year)	3 Registra	Wilkley Mar's Signature	0 10	4a	y.		UNIVO	10 011	01.	~0/35
	Registr	٠,	APR 1 4 200	5 Som	s to Apra	W							

		1 - State Registrar 1. Decedent's Name (First, Middle, Las	C	partment of Health and ertificate of Death		eg. No. 200	3. Time of Deat
Physici /Media	cal	No1a Irene 4a. Fecility Name (If not institution, give	Fawks	4b. City, Town, or Location of Deat	April	fð 2005	5 5:20 A
Examir Funeral	ner	Millenium Health a 5. Social Security Number 6. Se	and Rehabilitation 7. Age (In yrs. last birthda	Glen Burnie	9 Date of Birth	0 B:	runde1
Director		236-22-1777 19 19 19 19 19 19 19 19 19 19 19 19 19	□ M 213 F 83 Yrs.	Months Days Hours Min.	(Month, Day, 01/07/1	922 C	ountry) KY
Items 23a or 28a-f show	ector	MD Baltimore	e City Baltimor	e			10d. Inside City Lin
23a or	Funeral Director	411 Fawcett Stree	et	10f. Zip Code 21211	10	0g. Citizen of What Co USA	ountry?
e , o	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2 No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: W	
- 4	Completed	15. Decedent's Ed (Specify only highest grad Efementary/Secondary (0-12)		pedent's Usuaf Occupation we kind of work done during most of wor . DO NOT use retired)	king	16b. Kind of Business	/Industry
d othe	Be	17. Father's Name (First, Middle, Last)		erwriter 18. Mother's Nam	ne (First, Middle, M	Insurance Maiden Sumame)	Company
and Menta is marked aumatic av	ို	Russell Cline 19a. Informant's Name/Relationship (T)	ype, Print) 19b. Ma	Holly Billing Address (Street and Number or Ru		City or Town State	Zin Code)
Health a am 27 is ther tra		Mr. Larry Cline /	Son 110	Louise Terrace, G	len Burn		060
rtant: If rjury or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens	Crestlaw	n Mem. Gardens 4/1 22. Name and Address of Facility Si	3/2005 N	Marriotsvi Funeral Ho	lle, MD
Impo any ii		Thickille C	1 m	1 Second Avenue SW	, Glen Bu	ırnie, MD	21061
nysician Medical xa defached for use as the burial-transit	Ilcal Examiner	fmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Anythina			Onset and Deat
y the attending pached for use as	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
been signed t should be det	ed by PI	Part II. Other significant conditions col	ntributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	
is certificate has been director, page 2 should	Completed by	Cheuce	Kencel use	ff.	24a. Was an autopsy performe 1 Yes 20	prior to d	topsy findings avail- ompletion of cause
certifi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital:	04	h (Check only one)		
= 6	atlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 2 ER/Outpatie 28b. Time Injury	ant 3 DOA 4 Virursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Spec	ify)
within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et end Number or Ru State)	ral Route Number,
nera / fille	Medical (29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Medical Examination (Check only one)	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau ed at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
in 24 h	5	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month	Day, Year)
within 24 hours afte To the Funeral Dir completely filled in) (4)		D67028		4-11-1	5

		For State Registrar		•	epartment of Certificate o		2. Date of D	Reg. N	200	5 126	92
Physicia		1. Decedent's Name (First, Middle, L Carol Ann Galla					Month APICIL			3. Time of D	
/Medic		4a. Facility Name (If not institution, g	ive street and number)			n, or Location of De	ath	4	c. County of I		
			Sex 7. Ag	e (In yrs. last birtho	PALTIM (av) If Under 1 Yea	ar If Under 24 H	rs. 8. Date of B	irth	9.	Birthplace (State or	Foreian
Funeral Director		217-40-0973	1□M 2⊠F	64 Yr	Months Day	ys Hours Mi		ay, Year	941 M	Birthplace (State or Country) aryland	
Mo M		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location					10d. Inside City	Limits
nd Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Maulcal Estroiter mast be notified at	Director	Maryland Baltim	ore	Cat	onsville					1 ☐ Yes 2	2 X M0
a or 28 Leans	Dire	10e. Street and Number 2229 Pleasant	Desire		10f. Zip Code	e 21228			itizen of Wha	it Country?	
ms co	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify C		(Specify Yes or N		14. Race -	American Indian,	<u>-</u>
is marked other than "natural", or items 23a or 28a-f show aumatic event, the Mazical Establing mast be rediffed at	by	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	1 Yes 2 XI If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☑ N		erto riicari, etc.)		Specify:	White, etc. White	
all of the second	Completed	15. Decedent's (Specify only highest of		16a. D	ecedent's Usual Occ Give kind of work dor fe. DO NOT use ret	cupation ne during most of w	vorking	16b.	Kind of Busin	ess/Industry	
I've M	omp	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Receptioni				Dental	Office	
vent,	BeC	17. Father's Name (First, Middle, La.	*	,		18. Mother's N	ame (First, Middi	le, Maide			
e o i i e	Tof	Millard A. Slaug					E. Stein				
traum		19a. Informant's Name/Relationship Ann M. Gallagher			Mailing Address <i>(Str</i> e 29 Pleasan					_{ite, Zip Code)} v1and 2122	g.
other		20a. Method of Disposition			isposition (Name of crematory or other p		Date	_		y or Town, State	
ILY OF		1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec			awn Cemet	1	-14-2005	Mai	rriott	sville, MI)
Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Juneral Service Lice	Lelson	selee	22. Name and Add Witzke Fu 1630 Edmo	dress of Facility ineral Ho ondson Av	me of Ca enue Cat	tons	ville,	Inc. MD 21228	
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused	the death. Do no		and the second s				Approximate Interval Between Onset and De	een
sician		Immediate Cause (Final disease or condition resulting in death)	a. FUNG							~WEEKS	
dical niner		resoning in douiny	Due to (or as	a consequence of	:					2 4 4 1	CHTHS
	Jer	Sequentially list conditions, if any, leading to immediate	D	a consequence of	:						
burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		PAKALTSIS					24 MON	ZHTL
2	Ö	resoluting in deality Last	Due to (or as	a consequence of	<u>. </u>						_
for use as the	Medi	IF FEMALE:	00- 16	-4							
detached for us	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death	3 □Ectopic pregna 5 □ Other (specify)				23d. Date o Month	f delivery Day Y∈	ar
d be deta	by	Part II. Other significant conditions CORCNART AR	contributing to death b	_	he underlying cause	given in Part I.				ite to the cause of de	
s been signed t	ietec						24a. Wa	ıs an	24b. Wei	re autopsy findings av	zailable
m C4	Completed							opsy formed? 2 12 N	prio dea	r to completion of car	use of
is certificate ha	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only				
	7: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a, Date of Inju			Other: 4 Nursing njury at Work?	g Home 5 ☐ Re 28d. Describe			(Specify)	
on fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		ly Year) Inj		work? 1 □ Yes 2 □ No					
al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not determine	A 200. Flace of fill	jury - At home, farn tc. <i>(Specify)</i>	n, street, factory, offic	ice	28f. Location City or T	(Street a own, Sta	and Number (te)	or Rural Route Numb	₿ <i>r</i> ,
To the Funeral Director: After this completely filled in by the funeral di	Medical (Physician: To the best aminer: On the basis o and manner st	of examination and/							
To th	Me	29b. Signature and title of certifier	I M M	110 110	ı	ense number				Month, Day, Year)	
		Maria Carme				18614		APR	11,2	2005	
10		30. Name and address of person wh MARIA CARRIELA N.	ROSALES	900 CAT		BACTIMOR	E, MO	212	29		
Sta Registra		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	. M. A.	lasti)					-

DHMH 17 Rev 1/2001

GALLYCHER, CARCL A

			1 - For Stete Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F			iene	05	12693
		an	1. Decedent's Name (First, Middle, I	_ast)				2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		Dorothy Lucil			T		April	10	2005	8:40A M
4	Examir	ner	4a. Facility Name (If not institution, g)	4b. City, Town, o	r Location of I	Death	4c. Coun	ity of Death	
		ė	5407 Montbel A		and the same track himbertan	Balti If Under 1 Year	imore	l Hea Land			
	Funeral Director		235-34-2864	1 □ M 2 🖾 F	ge (In yrs. last birthday) 79 Yrs.	Months Days		Min. (Month, Day,		9. Birthp	tace (State or Foreign try)
			Usual Residence of Decedent		19			May 17,	1925	west	Virginia
	nyian how		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. tnside City Limits
	e Ma	cto	Maryland		Bai	Ltimore					1½ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen o	What Cour	itry?
	ath w		5407 Montbel A			2120	7		U	.S.A.	
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-t show ta Madical Exemirer must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married		? No			n? (Specify Yes or No- Puerto Rican, etc.)		ace - Americ lack, White,	
Maryland 21215-0036	iral',	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔽 No	Specify:		Spec	whi	te
5-	d within 72 ho piene. r than "natur ine Medical	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Give	dent's Usual Occup	durina most o	of working	6b. Kind of	Business/Ind	dustry
12	withir ene. than	d d	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired					
d 2	iled tygi ther		17. Father's Name (First, Middle, La.	st)	Asser	ibly Line		e Painter S Name (First, Middle, M			ing
an	should be fand Mental Fand Mental Fands Mental Fands of umatic ever	To Be	Clarence Gord					a Lillian C		2110)	
ary	s 1 and 2 should be if Health and Menta Item 27 is marked other treumatic e	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street		or Rural Route Number,		n, State, Zip	Code)
			Phillip M. Godwi	n (Son)	1401	Clairidge	e Road	Baltimore	Mary	land	21207
ore	iges 1 and 2 at of Health it Item 27 i or other tre		20a. Method of Disposition		20b. Place of Dispo					- City or To	
Ë	Pages ment of I ent: It Its ury or o		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec			Cemetery		-14-2005	Vood1a	wn, Ma	aryland
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Feneral Service Lio	De la	Wi	Name and Address	eral Ho	ome of Cato	nsvill	le. In	C -
			23a. Part1. Enter the disease, or co	mplications that cause	d the death. Do not ent			venue Cato		Le, MD	21228 Approximate Interval Between
	Pnysician		shock, or heart failure. List on Immediate Cause (Final	y one cause on each i		a-ch ()		- (-			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	nectal i	QNC	en		- 0	zyeans
ı	Examiner		Sequentially list conditions,	b							
	p tis	lner	if any, teading to immediate		a consequence of):						-
_	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit				, a 30, 304 a 31, 50 o 1, 5						
687	ficate p phys	edlcal		d							
Вох	leath certific attending p I for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. D	ate of delive	v
	death e atte	Physician/Me	in the past 12 months?	4☐Pregnant a		lEctopic pregnancy] Other (s <i>pecify)</i>					Day Year
P.O.	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknown							
	es that igned b	by	Part II. Other significant conditions	contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	./	ntribute to th	e cause of death?
ord	w requir been si should	ted						1 □ Ye	2 100	3 Proba	ably 4 □Unknown
Vital Records,	us ou or	Completed						24a. Was an autopsy		prior to con	sy findings available appletion of cause of
a F								perform 1 ☐ Yes 2	No No	death? 1 🗆 Yes	2□ No
Ë	Physicien: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe		Death Check on one			
of	Phys ral di	To To	1 ☐ Yes 202 No 27. Manner of Death	1 ☐ Inpati		1 3 DOX	4 🗆 Nursii	ng Home 54 Resider 28d. Describe how)
O	nding th. : Afte s fune	tlor	1 Natural 5 Pending 2 Accident investigati	(Month, Da	y Year) Injury	28c. Injury Work M 1 🗆	k?" Yes 2∐No		v anjuty occu	iii od	
Division	Attendi	ifica	3 Suicide 6 Could not determine	d 286. Place of in	jury - At home, farm, str	eet, factory, office		28f. Location (Stre	et and Num	ber or Rural	Route Number,
Ö	s after s after of Dire	Certification:	4 Homicide	building, e	tc. (Specify)			City or Town,	State)		
	To the Hospitel or Attending Physicien: whim 24 hours after deals are callic. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only 20) Medicel Exe	hysicien: To the best	of my knowledge, death	occurred at the tim	ne, date and p	place, and due to the car	use(s) and m	nanner as sta	ated.
	To the P within 2 To the P complete	Medical	0/10/	and manner st	ated.						
1	To To		29b. Signature and title of certifier			29c. License	number	29	u. Date sign	ed (Month, E	vay, Year)
1	3		20 Name and address of several		looth (Itom CO-) CT	103	292	4 14	-12.	-65	
	1,		30. Name and address of person who	MM 90	DCo Lara - (Type,	Tale B	A T.	more M	N >	420	9
	Sta	te	31. Date filed (Month, Day, Year)		rar's Signature	AVE O	- 1 <u>- 1 </u>	A VIOICE Y	-0 -		
	Registra	ar	Al	PR 1 4 2005	Elever.	H. Joan	w .				

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Year April 10 **Physician** Gee 4:12 PM Edsell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Severn Anne Arundel 8056 Telegraph Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1⊒M 2□F 228-28-2216 77 Apr. 10,1928 Director VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23s or 28s-f show ury or other traumette event, the Mudical Examines must be inclined at 1 ☐ Yes 2 ☐ No Director Anne Arundel Severn 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 8056 Telegraph Road U.S.A. 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 X Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Salesperson Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Henry Gee Alena May Sweeney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr 701 Fernhill Road, Baltimore, MD 21226 Mrs.Etta Rickell / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Meadowridge Memorial | Apr 14,2005 Elkridge, MD * 4 □ Denation 5 □ Other (Specify) re of Funeral Service Licenspe 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signatu MO1190 1 Second Avenue S.W., Glen Burnie, MD 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final di vary or condition resulting in death) **Physician** Byears leena corcinoma /Medical Due to (or as a consequence of): Examiner Macco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and -transit Due to (or as a consequence of): physicien ar Physiclan/Medical the attending phed for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 18 Yes 2 No COPD 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CAD has page 2 autopsy performed certificate 1 Yes 2 No 1 Yes 2 No ector. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? : After t Certification: Attending 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No death. investigation Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide determined within 24 hours after To the Funeral Dire 4 Momicide To the Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Revie Partholi 30. Name an, address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Annapolis Rd 1215 32. Registrar's Signature State APR 1 4 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

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Records,

Vital

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Division

		State of Maryland / De	partment of Health and N	Mental Hygie	ne,	10000
		1 - State Registrar	ertificate of Death	Reg.	No. UUD	12696
Physic	ian	Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
/Medi	cal	Ralph H. Green 4a. Facility Name (II not institution, give street and number)	4b. City. Town, or Location of Death	April 8	2005 4c. County of Death	2345 M
Exami	ner	Anne Arundel Medical Center	Annapolis		Anne Aru	nde1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
Director		218-36-0327 ISM 2□F 66 Yrs. Usual Residence of Decedent		April 28	1938 Ma	ryland
/land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Man a-fsh	ctor	Maryland Anne Arundel Annapo	olis			11∑Yes 2 ☐ No
or 28	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	
eath v	Funeral Director	1916 H Copeland Street 11. Marital Status 12. Was Decedent Ever in U.S. 1	21401 3. Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - Ameri	USA can Indian,
ifter d		1 ☐ Never Married 2X Married 1 ☐ Yes 2 XNo	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
ours a	dby	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 √2 No Specify:			lack
natu	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of work s. DO NOT use retired)	king 16t	o. Kind of Business/Ir	dustry
withir iene.	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	uck Driver	R	onald Re	ed Co.
e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai		
at yiellid A IA 12-0000 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. It marked other than "natural", or Items 23a or 28a-1 show umatic event, Ita Modical Examination ust be notified at	은	James Green		e Brown		
Mar d 2 sho h and 7 ls my traum		, , ,	ailing Address <i>(Street and Number or Ru</i> L6 H Copeland St			
ite; INIAI yidalid x 12 12-0000 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. tiem 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it a Modical Examiner and be multiled at		20a Method of Disposition 20b, Place of Dis	sposition (Name of crematory or other place)		. Location - City or T	
mit. Pages partment of I portant: If its y injury or o			cest Cemetery 4	/14/05	Annapoli	s, Md.
Dallinge, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Wm Reese & Son	s Mortua	rv. P.A.	
n go = e o		23a. Part 1. Enter the disease, or complications that caused the death. Do not	Wm. Reese & Son 821 West St. An	napolis,	Md. 214	O 1 Approximate
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
Pnysician /Medical		disease or condition resulting in death) a	a conces			
Examiner	Ι.	Sequentially list conditions, b. Turny C	ance			
V per led √	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
execution and ial-trage	Examin	that initiated events c. Due to (or as a consequence of):				
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cal	d				
wrequires that the death certifics been signed by the attending phe should be detached for use as it	Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
Both cer attendir for use	Physician/Med	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
cy the dached	hysi	1 Yes 2 No 9 Unknown				
S, T es tha igned be del	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		2 No 3 Pro	he cause of death? bably 4 Dunknown
v requires	eted			•		
VICAL MEC Sician: The law s certificate has b lirector, page 2 s	Completed			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
VICAL I	e Co	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 ☑ ath (Check only one)	No 1 ☐ Yes	2LI No
OI VITA Physician: rthis certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		ome 5 Residenc	e 6 □Other (Speci	fy)
on or vital meding Physician: The land. After this certificate he funeral director, page.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju		28d. Describe how	injury occurred	
Vitending death. ctor: Afte y the fune	licat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm.		28f. Location (Stree	et and Number or Rui	al Route Number,
alor A s after N Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place ir investigation, in my opinion, death occu	, and due to the caus	se(s) and manner as and place, and due	stated. to the cause(s)
o the Arithin 24 on the Pomplet	Med	one) and manner stated. 29b. Signature and title of certifier 4	29c. License number		Date signed (Month	Day, Year)
F . ¥ F 8		I Cintis Hom. M	D 03300		4/11/	05
1		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	1	1 1111	·ŕ
6		31. Date filed (Month, Day, Year) 32 Registrar's Signature	te Rd Ste HI Ann	90115, 11	D 7196	<u></u>
S Regis	tate trar	APR 1 4 2005	perte			
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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 13, Ida R. Hoff 2005 6:20 A M April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6336 Cedar Lane Columbia Howard 8. Date of Birth (Month, Day, Year) 8 1906 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2 💢 F 088-05-9528 98 Russia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County marked other than "netural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Funeral Director Maryland Howard Columbia 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6336 Cedar Lane 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZMo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Seamstress Hotel / Casino 8 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages I and 2 should be file Department of Heelth and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Meir Reiman Hannah Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5023 Rushlight Path Columbia, Maryland 21044 Raymond M. Hoff, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/14/05 Metro Crematory Inc. Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eagh line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eumnis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner (AnnioVAille Hypertensur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month filled in by the funeral director, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 🔀 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 □ No 1 Yes 2 **X** No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death after death. I Director: After t Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 1055 (it/le Patrixent 31. Date filed (Month, Day, Year) 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		State of	Marylar				lealth a Death			Reg. No	200)5	12698
	Physicia	ın	Decedent's Name (First, Mid	dle, Last)		1-tary	140					Month	Day			3. Time of Death
1	/Medic	al -	4a. Facility Name (If not institut	on cive s	met and num		-	4h City	Town or	Location (of Death	4. County of Death NA 8. Date of Birth (Month, Day, Year) 4-15-22 10g. Citizen of What Count USA Decify Yes or No- of Rican, etc.) 14. Race - America Black, White, e Specify: Bla king 16b. Kind of Business/Ind Day Care ne (First, Middle, Maiden Sumame) Roundt tral Route Number, City or Town, State, Zip of timore, Md. 21239 Date 20c. Location - City or Tow 16-05 Ayden, N.C. Baltimore, Md. 1101 E. North Av cor respiratory arrest, 23d. Date of deliver Month 23e. Did tobacco use contribute to the 1 yes 2 No 3 proba 24a. Was an autopsy performed? 1 Yes 2 No 3 roba 24b. Were autoprior to com death? 1 yes 3 No 1 yes ath (Check only one) lome 5 Residence 6 Other (Specify) ath (Check only one)	7 - 7			
	Examin	er	Lorien		k Gon					`~ore				_		
-	Funeral		5. Social Security Number	6. Sex		. Age (In yrs.	last birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	th V Year)		9. Birthp	lace (State or Foreign
п	Director		239-24-8701	1 🗆	M 2 X 1F	82_	Yrs.	Months	Days	riouis	IVIIII.	4-15-	-22			N.C.
	pu k		Usual Residence of Decedent 10a, State 10b, Cour	hv .		10c. Ci	ity, Town or Lo	ocation							year c 5 5 5 Inty of Death NA 9. Birthplace (State Country) N. 1 10d. Inside 1 M Ye of What Country? USA Race - American Indian, Black, White, etc. scify: Black of Business/Industry Care name) Roundtree wm, State, Zip Code) 21239 on - City or Town, State On, N.C. re, Md. 21 orth Ave. Approximaterval Bonset an 11 Date of delivery Month Day Date of delivery Month Day Contribute to the cause of death? 1 Yes 2 No Other (Specify) Industry Contribute of Rural Route No. Other (Specify) Industry Contribute of Rural Route No. Contribute of Rural Route No. Other (Specify) Contribute of Rural Route No.	0d. Inside City Limits
	Aaryla r sho	ŏ	Md.	NA		İ	Baltim							Day Year 1 C County of D. NA Year) 9. E 22 Dg. Citizen of What USA 14. Race - A Black, W Specify: 16b. Kind of Busine Day Carrelaiden Sumame) ROU. City or Town, State 10c. Location - City Ayden, N timore, I E. North st, 23d. Date of Month acco use contributes 22 No 3 23d. Date of Month st, 23d. Date of Month acco use contributes 24b. Wera prior death 1 North st, 24b. Wera prior death 1 North st, 24b. Wera prior death 1 North st, 24b. Wera prior death 1 North acco use contributes 25d. Date of Month acco use contributes 25d. Date of Month 27d. Date of Month 1 North 27d. Date of Month	1⊠Yes 2□No	
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	be filed within 72 hours after death with the Maryland stal Hygiene. ad other then "netural", or Itams 23a or 28a-f show event, if a Mydical Examinar must be notified at	by Funeral Director	249 St. Matt	hews	Street				212	202				USA		
	deat	ner	11. Marital Status	1	2. Was Deced	dent Ever in U	J.S. 13.	Was Dece	dent of Hi cify Cuba	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.))-			
98	or Ita	y Fu	1 Never Married 2 M		1 Tes 2 If Yes, Give Year or Dat	2 L'XNo		1 Yes		Specify:						
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pu	be filed tal Hygid d other event, II	Bec	17. Father's Name (First, Midd	e, Last)		_							, Maiden			
ylaı	should be nd Mental markad o umatic eve	2	Henry			Rog	jers				Catie					
Maryland 21215-0036	and and is m		19a. Informant's Name/Relation													Code)
	s 1 and 2 if Health itam 27 othar tra		Donnie C. H	arper	. S	on 20b.	Place of Dispo	osition (Na	me of							own, State
nor	Pages nent of int: if it ury or o		1 Burial 2 Cremation 4 Donation 5 Other		amoval from S	ו פובו.	cemetery, cre. Ayden			(e)	4-1	.605	Avo	den,	N.C.	
Baltimore,	# 문란금 .	19	21. Signature of Funeral Servi		0					ss of Facili	ty	Ba				
B	Depa Impo any i		> ble	ميل	, w	ano	2	Marc	h F.	H. Ea	ast					
1	Pnysician /Medical Examiner	T	shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or complication on a	Due to (C	ech line.	quence of):									Interval Between Onset and Death II day 6 mon Ks
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate the conditions of the con			or as a conse	quence of):									
P.O. Box (ires that the death certif signed by the attending I be detached for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23		nth 2 ∏Fet ant at time of	al death 3[⊒Ectopic p ⊒ Other (s)		·						2
	ss tha gned se det	by P	Part II. Other significant cond						cause giv	en in Part	l.					
ord	w require been si should		Periphena	U	ascul	ar 1	Disper									
Division of Vital Records,	hysician: The law i his certificate has b I director, page 2 sh	Completed										auto	psy ormed?	pri de	or to coath?	mpletion of cause of
Vita	ician certific ector	Be	25. Was case referred to med examiner?	10.7	ospital:				Oth							
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o	ding th. After	tion	1 Satural 5 ☐ Per	ding stigation	28a. Date o (Month	n, Day Year)	Injury	М	28c. Injur Wor 1 □	k? Yes 2.⊟	No					
Divisi	at or Attanding atter death. I Diractor: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be imined	28e. Place buildin	of Injury - At I ig, etc. <i>(Spe</i> c	home, farm, st	reet, factor	y, office			28f. Location (City or To	Street ar wn, State	nd Number e)	or Rura	Il Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier Certification (Check only one)	ying Phys el Exemir	sicien: To the ner: On the ba and mann	sis of examin	nowledge, dea nation and/or in	th occurred	at the tir	me, date ar opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s date and	and mani d place, an	ner as s	tated. the cause(s)
	To the within To the comp	M	29b. Signature and title of cert	fier) /			29		e number			29d. Da			
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	4)		30. Name and address of pers	_	1 /				, 1.		A)) / (0.01017
	7		31. Date filed (Month, Day, Ye	Z	1 to u c	ogi s frar's Sign	171L	T []	UMI	v	1666	190	15	nort	1	7 21214
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 2000

		Certificate of Death	nd Mental Hygiene 2005 2699
	Physician	1. Decedent's Nam <i>e (First, Middle, Last)</i> William H. Hite	2. Dete of Deeth Month April 6, 2005 3. Time of Death 12:20AM
	/Medical Examiner	4e Fecility Neme (If not institution, give street end number) 4b. City, Tow	m, or Location of Death 4c. County of Deeth
	2 4	Pineview Nursing and Rehab. Clint	on Prince George's
	uneral rector	5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 F 86 Yrs. 7. Age (In yrs. lest birthdey) Months Deys Hours	4 Hrs. Min. July 27,1918 8. Date of Birth (Month, Dey, Yeer) July 27,1918 9. Birthplace (State or Foreign Country) Virginia
and	ž	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
Many	123a or 28a-f show sast be notified at rai Director	Maryland Prince George's Fort Washington	1 ☐ Yes 2 🔀 No
the	be notified Director	10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?
h wit	a di	3408 Oaklawn Road 20744	U.S.A.
deat	r tams 23. diner mant Funeral	11. Maritel Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Original International	in? (Specify Yes or No- Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Maryland 21215-0020 d 2 should be filed within 72 hours aftar death with the Maryland th and Mental Hygiene.	b e	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1943 − 1 □ Yes 2 ☒ No Specify: 1 □ Yes 2 ☒ No Specify: 1 □ Yes 2 ☒ No Specify: 1946	Specify: White
5-0 72 hc	nt, the Medical It, the Medical Completed	15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most life. DO NOT use retired)	of working 16b. Kind of Business/Industry
vithin ene.	L L	Elementary/Secondary (0-12) College (1-4or 5+)	
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aryla should and Men	7 is marka traumatic To		or Rurel Route Number, City or Town, Stete, Zip Code)
Ma Md 2 s Th an	trau	, , , , , , , , , , , , , , , , , , , ,	t. Washington, MD 20744
Heal	other o	20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place)	April 12,200 Location - City or Town, State
Baltimore, Demit. Pages 1 ar Departmant of Hea	= 5	1 X Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Washington National Cem	
nit. P	mportant: any injury ance.		Lee Funeral Home, Inc.
	any i		dria Ferry Road CLinton, MD20735
		23a. Pagy. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c	ardiac or respiratory arrest, Approximete Intervel Between
/Me Exa	sician edical miner	Immediate Ceuse (Final disease or condition resulting in deeth) ATTENDIOCUERTO AND Due to (or as e consequence of):	Onset and Death OUASCULAR DUSASSE YEARS
os ou.	g physician and as the burial-transit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as e consequence of): Due to (or as e consequence of):	
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that	be deta	DEMENTIA	
4) =	s been s 2 should pleted		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
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	irector, page 2 s	25. Was cese referred to medical 26. Plece	of Death (Check only one)
OT VITA Physician:	his cer Il direc	examiner?	sing Home 5 Residence 6 Other (Specify)
Ing Phys	After th funaral fon:	27. Menner of Death 1 Matural 5 Pending (Month, Dey Year) 28. Injury at Work? 28. Injury at Work? 1 Yes 2 N	28d. Describe how injury occurred
UNISION I or Attending after death.	al Diractor: After t lad in by the funare Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 189. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours	To the Funeral Director: After this certificate ha completely filled in by the funaral director, page. Medical Certification: To Be Completely and the complete of the complete of the complete of the complete of the comp	29a. Certifier (Check only one) 123, Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death end manner stated.	
To th withir	To the	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		11/105	45 APRIL 6, 2005
	1211	30 Name and address of person who completed cause of death (Item 23e) (Type, Print)	COUTER WALVONE, MOD. 2005
		1 = WISON WAY WILL CON UNCE	EUICE WHOU I MU. CO
7.7764	State	31. Date filed (Month, Day, Year) 32. Registrer's Signatur	

DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	laryland		artmen <i>rtificat</i>			and Me		giene Reg. No		236	1 " " "	0.0
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of Dea		UU	ar	3. Time of D	Doath
	/Medi			lary Carr			44 14					8, 2	Day Year, 2005 4c. County of Dea Montgo 1914 Mic 1914 Mic 10 Citizen of What County of Black, White Specify: White Specify		4:10	A ^M
7	Examir	ner	4a. Facility Name (If not institution, give s Summerville Assist						Location o	of Death		4c.			2477	
	Funeral	-	5. Social Security Number 6. Sex		ge (In yrs. la	st birthday)	If Under		If Under :	24 Hrs.	8. Date of Birt	th				Foreign
	Director		523-48-1667	M 2⊠F	91	Yrs.	Months	Days	Hours	Min.	Month, Da March 22	y, Year) , 19		Counti	n/)	3
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation									. 1 1 14
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	288-	rect	Maryland Montgome 10e. Street and Number	i y		1	3ethe					10g. Cîtîz	zen of Wha	t Count	rv?	
	h with	ai Di	6701 Barr Road					208	316			Uni	ted S	Stat	es	
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show ta Madical Evanti et mast ke nolitied at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces		. 13. \	Was Deced	dent of Hi	spanic Orig	gin? (Spec	cify Yes or No- lican, etc.)	- 1				
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give	No		1 ☐ Yes				, , , , , , ,					
21215-0036	tural	ed b	15. Decedent's Edu	Year or Dates:		16a. Deced	ient's Usua	al Occupa	ition			16h Kir	nd of Busin	ess/Indi	etry	
215	hin 72 s. in "ne in "he	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or	5+)	(Give life. L	kind of wo DO NOT us	rk done d se retired,	uring most	of workin	g				,	es
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Ma	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Bruce F. Hill/Son	oe, Print)											Jode)	
ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nan	ne of	1 "	Da	ite				n, State	
E	Page nent o int: ff iry or		1 ☐ Burial 2 ☒ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Moñí Crei	netery cren Egomer natori	y um	Inc.	" A	pril 200	11,	Beth	esda.	Ma	rvland	
Baltimore,	permit. Departm Importa any inju		21. Signature o Funeral Service License	90					s of Facility				Bet	hes	la-Che	vv
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			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that cause le cause on each l	d the death. ine.	Do not ente	er the mod	e of dying	, such as	cardiac or	respiratory ar	rest,	Boy No. 2005 Ac. Country of Death Montgomery Year) 1914 Montgomery 9. Birthplace (State or F. Country) 1914 Inchigan 10d. Inside City 1 Yes 2 0g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry National Institute of Health Maiden Surname) City or Town, State, Zip Code) Pland 20816 20c. Location - City or Town, State Bethesda, Maryland Home / Chase, Inc. MD 20814-3501 ast, Approximate Interval Between Onset and Death? 1	nterval Betwe		
	Pny sicia n /Medical		Immediate Cause (Final disease or condition resulting in death)		ntia											
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V	icuted nd transii	Examiner	that initiated events													
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Ë	resulting in death) Last	Due to (or as	a conseque	ence of):										
387	physicate by street street.	dicai	d											+		
Box 6	eath certific attending p	∿/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome								2	3d. Date of	deliven	,	
	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 🔀 No	1 Live birth 4 Pregnant a			lEctopic pr Other <i>(sp</i>									аг
P.0	at the de I by the a stached	hys	9 🗆 Unknown	9□ Unknown												
	res tha signed be del	by	Part II. Other significant conditions con Hypertension	tributing to death t	out not result	ting in the ur	nderlying ca	ause give	n in Part I.							
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Records,	has ge 2 s	Completed	congestive heart	rallule							24a. Was a autop perfor	sv	prior	to comp	sy findings av pletion of cau	allable ise of
Vital		e Co	25. Was case referred to medical						OC Bloom	of Dooth	1 ☐ Yes	2 🔯 No			□ No	
<u> </u>	Attending Physician: r death. sctor: After this certific by the funeral director,	0 B	examiner?	ospital:	ent 2□El	R/Outpatien	t 3 DO	Othe			(Check only or e 5 ☐ Resid		Other (
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Division	vttendii death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	es 2□N	-						
ΟĬΧ	n te	rtifi	4 Homicide determined	28e. Place of In building, e	jury - At hom tc. (Specify)	ne, farm, stre	et, factory	, office		28	If. Location (S City or Tow	Street and m, State)	<i>Number</i> o	r Rural F	Route Numbe	∌ <i>Г</i> ,
_	spita ours seral filled		29a. Certifier 17 Certifying Phys	ician: To the hest	of my knowl	ledge death	occurred	at the time	e date and	1 place, an	od due to the o	Pauso(s)	and manno	r ac ctat	od.	
	To the Hos within 24 h To the Fur completely	Medical		er: On the basis of and manner st	of examinatio	n and/or inv	estigation,	in my op	inion, deat	h occurred	d at the time, o	date and	place, and	due to th	ne cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	N. Itto	0 .	11	29c	. License	number		2	29d. Date	signed (M	onth, Da	ay, Year)	
) Shama K	· Mitta	W, N			D006	1382			Apri	18,	2005	i	
	25		30. Name and address of person who co					11	1.50	D - 1		36		0.5.5	5.0	
	Sta	to	Shama R. Mittal, M 31. Date filed (Month Pay, Year) APR 14 200	32 Registr	16 Phy rar's Signatu		ns La	ine #	152,	KOCK	ville,	Mary	y⊥and	208	50	
	Registr	_	APR 1 4 200		w B		who									

			1 - For Støte Røgistrar		aryland / Dep		ealth and M	Mental Hyg	eg. No. CUU	1270
	Physic	ian	Decedent's Name (First, Middle, La Chrish, User)	st)				Date of Deat Month	Day Year	3. Time of Death
	/Medi	cal	Chieh Hsu	tract and number		45 C'- T-		April l	_	4:50 A M
1	Exami	ner	4a. Facility Name (If not institution, given Holy Cross Hospit			4b. City, Town, or Silver S			3.5	
	Funeral	_	<u> </u>		ιθ (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Director		213-08-4486 Usual Residence of Decedent	⊠ M 2□F	89 Yrs.	Months Days	Hours Min.	July 1,	Day 2005 4c. County of Death Montgome: 4c. County of Death Montgome: 7ear) 9. Birth Chi 7. Citizen of What County of Death Montgome: 7. Chi 7. Citizen of What County of Chi 7. Chi 7. Chi 7. Citizen of What County of Chi 8. Kind of Business/Ir 8. Kind of Business/Ir 8. Kind of Business/Ir 8. Kind of Business/Ir 9. City or Town, State, Ziging, MD 20 9. City or Town, State, Ziging, MD 20 9. City or Town, State, Ziging, MD 20 10. City or Town, State, Ziging, MD 20 11. City or Town, State, Ziging, MD 20 12. City or Town, State, Ziging, MD 20 13. City or Town, State, Ziging, MD 20 14. City or Town, State, Ziging, MD 20 15. City or Town, State, Ziging, MD 20 16. Location - City or Town, State, Ziging, MD 20 17. City or Town, State, Ziging, MD 20 18. City or Town, State, Ziging, MD 20 19. City or Town, State, Ziging, MD 20 19. City or Town, State, Ziging, MD 20 23d. Date of delivery Month 23d. Date of delivery Month 24b. Were autoprior to County Month 25d. No 3 Proto 27d. Date of delivery Month 27d. Date of delivery Month 28d. No 3 Proto 27d. Date of delivery Month 27d. Dat	ina
	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show alsal Examinar must be notified at		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Be-f e	cto	Maryland Montgome	ry	Silver Sp	ring				1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code		10	Day Year 4 2005 4 4 2005 4 4 2005 4 4 2006 4 2007 7 2 2 2 2 2 2 2 2	untry?
	s 23g	aral	320 Lyric Lane	10.14.	- I I I I I I I I I I I I I I I I I I I	20901				
	ter de	'n	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 21€1		Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spo I, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.
980	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21② No	Specify:		Specify: A S	ian
Ö	72 ho	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupat	tion			
21	within 7 ene. than "r	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5	(Give life.	kind of work done du DO NOT use retired)	uring most of work	ing		,
2	be filed within 72 hours after death with the Marylan Ital Hygiene et other than "naturel", or Items 23a or 28e-f show event, the Medical Evanther must be notified at	Co	12		Civ	il Servic				ernment
and	be fill	Be	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
ž	should be nd Mentai marked o	10	Shih Kou-Liang 19a. Informant's Name/Relationship (Toron Britan	100 14 10		Yang Shil			
Maryland 21215-0036	d 2 s th an th an traur		· `							
	permit. Pages 1 and 2 should b Department of Haalth and Ments Important: If item 27 Is marked any injury or other traumatic e once.		Catherine L. Shan 20a. Method of Disposition	g/ Daughte	20b. Place of Dispo	sition (Name of				
Baltimore,	ages ant of it: If if		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif		Montgon	natory or other place nery	April	16.		
Ħ	artme ortan injur		21. Signature of Fune/al Servic Lice		Crematori	. Name and Address	200 of Facility Rob	ert A. 1	Pumphrey Fi	maral Home
m	permi Depa Impo any ir		> Affron /	MO	0689 B	ethesda-Ch	nevy Chas	e, Inc.	7557 Wisco	onsin Ave.,
	Pnysician /Medical		23a. Flant, Enter the disease, or com shook, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	aIntracr	the death. Do not entered anial Bleed a consequence of):	er the mode of dying,	such as cardiac c	or respiratory arre	st,	Approximate Interval Batween Onset and Death 2 hours
8760, 7	rate be executed by sician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Creces or may) that initiated events resulting in death) Last	c	a consequence of): a consequence of):					
P.O. Box 68	The faw requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				,
	w requires tha been signed I should be det	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the ur	nderlying cause given	in Part I.			
S	aw re	plet						24a. Was an	24b. Were aut	opsy findings available
tal Re		e Completed	25. Was case referred to medical					1 Yes 2	ed? prior to condeath? No 1 \(\text{Yes} \)	ompletion of cause of
>	ysiciu is ceri direct	OB	examiner? 1 Yes 2X No	Hospital: 1 🖾 Inpatie	nt 2 ER/Outpatien		26. Place of Death			(4.1)
Division of Vital Records,	ding P. Afte fune	atlon: T	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		28c. Injury a Work?	at 2 No			19)
Divis	ital or Attenris after deatlial Director;	Certification:	3 Suicide 6 Could not by determined	28e. Place of Injubulding, etc	iry - At home, farm, stre :. (Specify)	eet, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1X Certifying Ph (Check only one) 2 Medicel Exem	ysician: To the best on hiner: On the basis of and manner sta	examination and/or inv	occurred at the time restigation, in my opin	, date and place, a nion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as see and place, and due t	stated. o the cause(s)
	To with To I	2	29b. Signature and title of certifier			29c. License r	number	29	d. Date signed (Month,	Day, Year)
			Paral He			D6003	8	C	4/12/00	~
	Ω_i		30. Name and address of person who			*				
	10		Padmalatha Moule, 31. Date filed (Month, Day, Year)	M.D. 1500	Forest Gle	n Road, S	ilver Sp	ring, Ma	ryland 209	10
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 1 4 20	05 Estre	s signature	will !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2. Date of Death **Physician** Month Day 04 05 /Medical Erma L. Halliday 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 064-20-9771 1 ☐ M 2 🎛 F 98 Yrs. Director 06/19/1906 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 27 Is marked other than "natural", or Items 23s or 28s-f show traumstic event, the Medical Exercities must be notified at Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 15030 Haslemere Ct. 20906 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ teacher 17. Father's Name (First, Middle, Last) Wallace Madison Stuart 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Ia rr any Injury or othar traum Malcolm F. Halliday/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ፟ Donation 5 ☐ Other (Specify) 21. Si natur Ronal d'Sicense Wade Director man Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate dause (Final disease or condition resulting in death) **Physician** Stroke /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2X No 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe Hypertension Completed Atrial fibrillation 24a. Was an certificate has autopsy performed? 2X No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 XNo 0 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Hospital or Attending 1 🔀 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) 24 hours a 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of certifier 29c. License number D5434 30. Name and address of person who eted cause of death (Item 23a) (Type, Print) Neeraj Chopra, M.D. P.O. Box 83819, Gaithersburg, MD 20883

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 3:00A 4c. County of Death Montgomery Birthplace (State or Foreign Country) Maine 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry education 18. Mother's Name (First, Middle, Maiden Surname) Elleta Jewett Burns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10602 Trotters Trail Potomac, MD 20854 20c. Location - City or Town, State State Anatomy Board 655 W. Baltimore Street Approximate Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably X□Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

State Registrar

31. Date filed (Month, Day, Year)

HALLIDAY

32. Registrar's Signature

2005

	•	For State Registrar	State of Marylan		artment of H			giene () () 5	12704
		1. Decedent's Name (First, Middle, Last)			, ,		2. Date of Dea	ith Nav Year	3. Time of Death
Physicia		Thomas T. I	Hunt				March	30 ^{Day} 2005 ^{Year}	2204 M
/Medic Examin	1	4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location of Dea	th	4c. County of Death	
	à	Anne Arundel Med	dical Cente	er	Annapo	lis		Anne Aru	ındel
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	r, Year) Cou	place (State or Foreign intry)
Director		214-26-7612	73	Yrs.			Oct. 3	1931 Mary	/land
pur *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation	· ·			10d. Inside City Limits
Aaryla F sho	ō	36	3	1 .					1⊠Yes 2□No
r the Maryland r 28a-f show	Director	Maryland Anne Ary 10e. Street and Number	undel Ani	napol:	10f. Zip Code			10g. Citizen of What Cou	intry?
th with 23a or ust be	<u>ā</u>	618 Severn Islan	nd Court		2140	11		USA	
leath ms 20	Funeral		2. Was Decedent Ever in U	.S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No-	14. Race - Ameri	
after or Item		1 Never Married 2 Married	Armed Forces? 12⊖XYes 2 □ No	-	If Yes, specify Cuba	in, Mexican, Pue Specify:	rto Hican, etc.)	Black, White	, etc. .ack
ral', c	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1952	2-54	1 ☐ Yes 2 ☒ No	эрвску.		Specify: B1	uch
filed within 72 hours after death with the Maryland Hygiene. Hygiene. ther than "natural", or Items 23s or 28s-f show ent. Item Medical Examination and the characteristics.	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done	during most of wi	orking	16b. Kind of Business/Ir	ndustry
an ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	•	Į	US Naval A	Academy
led w lygier her th		8th	0	Ma:	intenanc		ıme (First, Middle,	Stadium	
be fill hall hall hall hall hall hall hall h	Be	17. Father's Name (First, Middle, Last)							
y Indicated Indi	2	Royal Hunt	- Dei-Al	10h Maili	na Address (Ctrost		ella Jo	hnson r, City or Town, State, Zi	in Code)
12 should be filed withir h and Mental Hygiene. 7 Is marked other than traumatic event.		19a. Informant's Name/Relationship (Type			,			napolis, N	
s 1 and 2 should be filed within 72 hr thealth and Mental Hygiene. Item 27 Is marked other than "natur		Elaine Hunt (Wife	20h F	Place of Disne	sition (Name of		Date All	20c. Location - City or T	
Pages nent of int: If It		X Surial 2 ☐ Cremation 3 ☐ Re	moval from State Mai	emetery, cre rvlanc	matory or other place d Vetera	in ;			and services
그 두 열 글		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 	Cer	neter	7 2. Name and Addre	4/6	/05	Crownsvill	e, Md.
permi Departiment Importantiment		1 1 0	21. MOU483	Wi	n. Reese	& Son	s Mortu	ary, P.A.	\ 1
CONTRACT N		23a, Part1, Enter the disease, or complication	ations that caused the deal		21 West. ter the mode of dyir	St. An	napolis ac or respiratory ar	. Md. 2140 rest,	Approximate
		shock, or heart ailure. List only one Immediate Cause (Final	cause on such line.	-1	: -)	- 1-		1	Interval Between Onset and Death
Physician /Medical	١.	disease or condition resulting in death)	Due to (or as a consec	rns	Le Duc	orc			24 Milles
Examiner			Due to the as a consec		weer				
	ē	Sequentially list conditions, b.	Due to (or as a consec						
uted	Examin	Tany, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events							
be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):					
cate be executed only sician and the burial-transit	dical	d.							
The law requires that the death certificate ste has been signed by the attending phys page 2 should be detached for use as the	Jed	IF FEMALE:						- 10000	
death certifica attending pt	Physician/Me	23b. Was decedent pregnant 23	c. If yes, outcome of pregnance1 Live birth 2 Feta		☐Ectopic pregnancy	1		23d. Date of deliver Month	very Day Year
e dea he at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of of 9☐ Unknown	ieath 5	Other (specify)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	24,
that the dened by the a	Phy	9 Unknown	alle alle and another best and and	Minn in Abn		en in Don't	23a Did to	bacco use contribute to	the cause of death?
es tha igned be dei	by	Part II. Other significant conditions cont	nouting to death but not res	suiting in the t	inderlying cause giv	en in Fait i.		\	bably 4 Unknown
v require been si should b	ted								
law law las b	Completed						24a. Was autop	sy prior to c	opsy findings available ompletion of cause of
The sate h	Son						1 Yes	rmed? death? 2 XNo 1 ☐ Yes	2 No
sician: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	assital:		Oth	OF.	eath (Check only o		/
shysi this o	6	1 Yes 2 No	7	ER/Outpatie		4 🗀 Mursing		tence 6 Other (Spec	ify)
ling F	ion	27. Manner of Death i □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wai	yat k? Yes 2∐No	200. 00301001	low injury occurred	
ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of Injury - At h	ome farm s		103 2010	28f. Location (S	Street and Number or Ru	ral Route Number.
or All	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	reet, factory, office		City or Tox	m, State)	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the tuneral director, page		29a. Certifier 1 Certifying Physi	icien: To the best of my kn	owiedge, dea	th occurred at the til	me, date and pla	ce, and due to the	cause(s) and manner as	stated.
24 hos Prun etely	edicai	(Check only 2 Medical Exeminone)	of On the basis of examination and manifer stated.					date and place, and due	to the cause(s)
o the	Me	29b. Signature and talle of certifier	///		29c. Licens	e number		29d. Date signed (Month	Dey, Year)
->-0		* XX ()/(Sal		Dn	2594	9	3/31/200)
11		30. Name an old ss of per on to con	nplate use of death (Ite	m 23a) (Type	Print)	1	2 1 -	1	
111		MCVE	1 Au	12 F	29c. Licens D M Print)	V4let	(- C		
Sta	ate	31. Date filed (Month, Day, Year)	32. Pagistrar's Sign	ature	land to				
Regist	rar.	4 DD 1 A 20	195 Marian	17. 4	C3456				

		1	For State Registrar	State of Marylar		artment rtificate			nd Me		iene _{eg. No.} 2005	12705
	Physicia	ın	1. Decedent's Name (First, Middle, Les	\(\text{}\)					2.	Date of Death	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	Moryland		4b. City J	ult	IMOR	e ,	MD	4c. County of Death	
	Funeral Director		119-1-1-0-36	M 20F Age (In yrs	3 Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min. 8.	Date of Birth (Month, Day, 02-2	Year) P-(9/12 MARY	place (State or Foreign LAND
	uryland show		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo						Ac. County of Death N/A 4c. County of Death N/A 4c. County of Death N/A 7. Year) 10g. Citizen of What Cour USA 14. Race - America Black, White, Specify: BLA 16b. Kind of Business/In HOSPITAL Maiden Sumame) No. City or Town, State, Zip RYLAND 21216 20c. Location - City or Town Williams	10d. Inside City Limits 1 ☑Yes 2 ☐ No
	ath with the Maryland 123a or 28a-f show	Director	MD N/A		BALTIMO	10f. Zip C				1		21
	= 2	ra	1131 McKEAN AVE	12. Was Decedent Ever in I	U.S. 13.	212 Was Decede	nt of His	spanic Orig	in? (Specif	y Yes or No-	14. Race - Ameri	
336	or ite	by Fun	1 Never Married 2 Married Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2♥☐ No If Yes, Give 1 Year or Dates:		If Yes, specif		Specify:	, Ривло ни	can, etc.)	,	
21215-0036	"na"	Completed	15. Decedent's Ec (Specify only highest gra	ucation de completed) College (1-4or 5+)	(Give	dent's Usuat kind of work DO NOT use	done di	uring most	of working		16b. Kind of Business/Ir	ndustry
	illed within i Hygiene. other then "		Elementary/Secondary (0-12) -3- 17. Father's Name (First, Middle, Last)	-0-	COO	К		18 Mothe	r's Name (f	First Middle M		
Maryland	0 a 5 0	To Be	WILLIAM H. SMITH	I				RO	SIE T	HOMPSO	N	
Man	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (LORETTA LAWRENCI									
ore,	000		20a. Mathod of Disposition 1 🖾 Burial 2 🗹 Germation 3 🗆	20b.	Place of Dispo	osition (Name	e of ner place	e)	Dat	9	20c. Location - City or T	own, State
Baltimore,	permit. Page Department Important: I any injury o		* 4 □ Donation 5 □ Other (Specifical Signature Fineral Service License)	TOMATHAN D	HIBNE	Name and	Addres	s of Facility	-			
	Projection of Medical Examiner Medical Examiner Project Pro	icai Examiner	23a. Part / Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	()	ath. Do not en	ter the mode	of dying	MONR a, such as	cardiac or r	BALT	IMORE, MARY	Approximate Interval Between Onset and Death
.O. Box 68	Attending Physicien: The law requires that the death certificate death. death. ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	⊒Ectopic pre ⊒ Other (spe						very Day Year
α.	signed b	d by Pt	Part II. Other significant conditions of	dear of Fault	esulting in the u	underlying ca	use give	n in Part I.				
Division of Vital Records,	The law require cate has been sig page 2 should b	omplete	Renat Fail	ure						24a. Was a autops perform	med? prior to co	topsy findings available completion of cause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	☐ ER/Outpatie	ent 3□ DO/	Othe			Check on on		ifu)
on of	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)			Bc. Injury	at	28			.,,)
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be determined	B One Diego of frium. At	home, farm, st	treet, factory,	office		28	f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Directompletely filled in by	Medical C	29a. Certifier 1 Certifying Pl (Check only one)	nystcian: To the best of my k niner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred a nvestigation,	it the tim	ne, date an pinion, dea	d place, an th occurred	d due to the c	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	\Rightarrow		29c.	License	number	1014	2		
	_		30. Name and address of person who	Zirdoriam completed cause of death (It	(em 23a) (Type		1	10	100		04-12	- 6005
	3		1) 1/7	orian 2	2 Sou		re	n SI	rect	, Ku	Themore &	1D, Z1201
	Sta Regist		APR 1 4 2	37 Registrar's Sig	15 19	A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7:15 PM JONES APRIL CARTWRIGHT 2005 STEPHANIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) October 21, 1941 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Canada 195-38-5172 63 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ont: if item 27 is marked other then "natural", or items 23a or 28e-1 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "natural", or items 23a or 28e-f show other treumatic event, the Madical Exercitival Leads at 1 ☐ Yes 2 X No Director Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20015 United States 5508 Broad Branch Road, N.W. Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Private School Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Phyllis L. Hodges John H. M. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6314 Owen Place, Bethesda, Maryland 20817 David M. Evans / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition April 11. cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of importent: If eny injury or once. ō Bethesda, Maryland Montgomery Crematorium, Inci 2005 ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. selett M01305 64h 17557 Wisconsin Avenue, Bethesda, Maryland 20014-3501 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Physician septic shock /Medical Due to for as a consequence of): **Examiner** Qualificación de la consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit ed by the attending physicien and detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No 1□ Yes 2☑No Attending Physicien: 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Inpatient 2☐ER/Outpatient 3☐ DOA 10 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After I Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 0 To the Hospitel within 24 hours a To the Funerel C **Descriting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Todrumar M.D. APRIL 11, 2005 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALIDA PODRUMAR. SIDNEY KIMMEL CANCER CENTER. 1650 DRIEANS STREET. BALTIMORE, MD 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 4 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

egistrar's Signature

32

		•	State of Marylan	d / Depa		lealth and	Mental Hy	_	05 12707
Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last) S'TANLEY 4a. Facility Name (If not institution, give str 1042 MADISON ST		Ĵ	4b. City, Town, o	Location of Dea		5, 2005 4c. County	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		b T	9. Birthplace (State or Foreign Country) MARYLAND
the Maryland r 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD ANNE ARUN 10e. Street and Number		y, Town or Lo				10g. Citizen of \	10d. Inside City Limits 1 ☐ Yes 2 ☐ No What Country?
d 21215-UU36 filed within 72 hours after death with the Maryland Hygiene ther then "natural", or Items 23e or 28e-f show ont, the Medical Examiner must be notitled at	by Funeral D	1042 MADISON ST 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give	}	21403 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	USA 14. Race Blace Specify	ce - American Indian, ck, White, etc. fy: BLACK
ING 21215-0036 be filed within 72 hours aft tal Hygiene. d other then "natural; or event, the Medical Exam	Completed b	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) -12-	Year or Dates: ation completed) College (1-4or 5+) - 0-	(Give lite.	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking		Business/Industry
E d la be	To Be C	17. Father's Name (First, Middle, Last) GEORGE JOHNSON				ELIZA	ame (First, Middle, BETH S. F	ARKER	
ore, Maryls s 1 and 2 should of Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Typ: MARTON JOHNSON (1) 20a. Method of Disposition	WIFE)	104	ng Address (Street 2 MADISON sition (Name of			MARYLAN	
Baltimore, permit. Pages 1 an Department of Heal Importent: It item; any injury or other once.		1 ∑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	moval from State CROV	emetery, crei VNSVILI 22	matory or other plac LE VETERA	NS 4-1		COWNSVI	ILLE, MARYLAND MORTUARY, INC
Physician /Medical		23a. Part1. Ent of he disease, o's complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	n. Do not ent		ng, such as cardi	•		Approximate Interval Between Onset and Death
ate be executed axis yis ician and be burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseq						
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The la	e Completed	25 Man area referred to medical				GC Place of D	24a. Was autor perfo	osy rmed? 200 No	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
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DIVI:		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y) 		no data and pla	City or To	wn, State)	ber or Rural Route Number,
Divisit To the Hospital or Attenwithin 24 hours after dealt To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Medical Examinone) 29b. Signature and title of certifier	cien: To the best of my kno er: On the basis of examina and manner stated.	ation and/or in	vestigation, in my c	pinion, death oc se number	curred at the time,	date and place, 29d. Date signe	and due to the cause(s) ed (Month, Day, Year)
ſ _h		30 Name and address of person who con	npleted cause of death (Item	n 23a) (Type,	Print) A Mai	7936 alcala	nter 11	04-11	1-2005 eene st ve MD 21201.
7	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	turo			3	atma	3 E, NUO 21 401.

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month APR 2:00 AM Reid Kellam Leonard 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 900 CATON AVE, ST. AGNES HEAVITH Examiner NIA BALT IMOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Kend 5. Social Security Number 6. Sex **Funeral** 12 M 2□ F 219-50-2328 Director 16,1949 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Be Completed by Funeral Director Baltimore PIKESVIlle 10e. Street and Number 10g. Citizen of What Country? USA 21208 4633 Chickory Hill LANE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) f Health and Mental Hygiene. Elementary/Secondary (0-12) Enterreneural Philan tropist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Henry Reid Kellam Lelar Mae Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4633 Chickory Hill Lane Balto MD Mary E,
20a. Method of Disposition E. Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Zion Cemetery Apr 16,2005 Lansdowne, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rinald A. Grayson Funeral Home 108 W, March ave Back md 21201 Kinaed a. Brupon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATIC ENCEPHADOPATHY **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner END STAGE RENAL UNKNOW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be detached for use as the burial-transit SYNDROME UNKNOWN ACQUIRED & MMUNO and Due to (or as a consequence of) the attending physician Box 68760 Completed by Physician/Medical IF FEMALE If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an funeral director, page 2 autopsy perform this certificate Vital 1 Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury Division 1 Natural ours after dean.

*I Director: An.
in by the fur-5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C JECertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 18616 05 PRIYANKA NEWOK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 900 CATEN AVE, BALTIMORE, MD-21229 31. Date filed (Month) PRYear) 32. Redistrar's Signature State Marie H. Speck 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decadent's Name (First, Middle, Last) LE ENAN **Physician** 1CHAM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2AR) If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days 109M 2□F Hours Usuel Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State ral', or items 23a or 28a-1 show Exercites invist be positing at 1 Yes 2 No Directo 10g. Citizen of What Country? 10f. Zip Code INITED by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 □ No Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates: Specify: HITE 3 Widowed 4 Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMELMPROVENENT AINTER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic even UNKNOWN PRESTON UDSEPH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NIECE 3005 LAVENDER Health a KAREN ALAI 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Importent: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS REG. 4 Donation 5 Other (Specify) 21. Signature i Fun I Service icensee 22. Name and Address of Facility
Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a Part1. Enter the disease, or confilications that caused the seath, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ING CANCEL Physician disease or condition resulting in death) /Medical METATASIO **Examiner** Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a someousence of: The law requires that the death certificate be executed Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. I the a 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ BACCO 1 7es 2 No 3 Probably 4 Unknown 1(ひ)に Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 Inpatient Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) No No 2 ER/Outpatient 3 DOA Certification: To 1 TYes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Natural After 5 Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a McCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 48025 W

Registrar

State

30. Name and address of person who com

31. Date filed (Month, Day, Year)

CHEACO AVR, BATO, MD 21237

ed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

2005

			1 - For State Registrar		Maryla	nd / Depa		Health a	nd Mental Hy		2000	12710
	Physici /Medi		1. Decedent's Name (First, Middle, Last Lawrence H. Ka						2. Date of De Month April		Year 2005	3. Time of Death 4:30 P
	Examir	er	4a. Facility Name (If not institution, give				4b. City, Town,					
	Funeral		Charlotte Hall Ve 5. Social Security Number 6. Se	x 7		. last birthday)	Charlot If Under 1 Year				Day Year 2005 4c. County of Death St. Mary's 9. Birthplace (Country) 933 MD 10d. I 10d. I 14. Race - American Ir Black, White, etc. Specify: White b. Kind of Business/Industre 14. Balto., No. 15. Location - City or Town, State, Zip Code 17. Balto., No. 15. Location - City or Town, State, Zip Code 18. Application - City or Town, State, Zip Code 19. Padonia R Application - City or Town, State, Zip Code 20. No. 3 Probably 23d. Date of delivery Month Day 24b. Were autopsy fingerior to complete death? 10. Course contribute to the case of Complete Consideration of Complete Consideration of Considerat	
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	nyland show	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "naturat", or items 23a or 28a-f show event. The Medical Examinat must be notified at	Director	MD n/a 10e, Street and Number		В	altimor						1X Yes 2 No
	3a or	Ö	6711 Park Height	s Ava	Ant	<i>I</i> :11	10f. Zip Code 212	15		10g. Citiz	zen of What Co	
	death	Funeral	11. Marital Status	12. Was Deced	ent Ever in I				n? (Specify Yes or No Puerto Rican, etc.))- 1	14. Race - Ame	ncan Indian,
36	or ite	by Fu	1 Never Married 2 Married	1 XYes 2	! □ No		1 Tes, specify Cui 1 □ Yes 21X No		Puerto Hican, etc.)			
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Baltimore,	m O		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ P	Removal from St	20b.	Place of Dispo-	sition (Name of natory or other pla	ice)	Date	20c. Loc	cation - City or	Town, State
Ē	tment of Itant: If its		`4 ☐ Donation 5 ☐ Other (Specify)		1 -		of_Faith		/13/05	Balti	more, I	MD
Ra	permit, Page Department Important: If any injury or once.		21. Signature of Funeral Service Licens			22 L	Name and Addr.	Funeral	Home, 10	w.	Padoni	a Rd.,
			Michae J. Fla 23a. Part1. Enter the disease, or compl	ications that cau	ised the dea		lr	nonium	MD_2109	3		Approximate
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, S	be executed sicien and burial-transit		resulting in death) Last	Due to (or	as a conse	quence of):	100	7,6	VIFTAFI			
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õ ×	leath certificate attending phys I for use as the	/Med	IF FEMALE:	3c. If yes, outco	m a of progn	2001						
X Q	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		h 2 ☐ Fet	al death 3 🗌	Ectopic pregnanc Other (specify)	у		23		•
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_	ysician: ils certific director,	To B	examiner?	lospital: 1 ☐ Inp	atient 2] ER/Outpatient	3□ DOA Oth	or	Death (Check only or ng Home 5 ☐ Resid		□Other (Spec	ifv)
n 01	ding Phya h, After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Inju	y at	28d. Describe h			,,
Division	ttendi Jeath. tor: A the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		1.1. 441			Yes 2 □ No				
2	t or Al after of Direction by	Certification;	4 ☐ Hornicide determined	28e. Place of building	Injury - At h , etc. (Speci	ome, farm, stre fy)	et, factory, office		28f. Location (S City or Tow	treet and n, State)	Number or Rui	ral Route Number, •
	To the Hospital or Attending Physician: within 24 hours after deals within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	sicien: To the be	est of my kno	owledge, death	occurred at the til	me, date and p	lace, and due to the c	ause(s) a	nd manner as	stated.
	the H tin 24 the Fi	l edicai	one)	and manner	s of examina	ation and/or inv	estigation, in my o	opinion, death o	occurred at the time, o	late and p	lace, and due	to the cause(s) .
	Vit CO P	Σ	29b. Signature and title of certifier	1			29c. Licens	e number	47	111		, Day, Year)
	/1)		30. Name and address of person who co	moleted cause	of death (It-	n 232) (Trees 5	1) 0	0617	7 /	′/	11/6/	
	2		29449 Cha	OHE	. Ha	1) RD	cha	rlotk	Halln	20	201	250
	Sta		31. Date filed (Month, Day, Year) APR 1 4 200		istrar's Signa	ature do	refer	1-1-			- 416	
	Registra	ar	ALUT 4 COT	J 39'00' 100'								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 1^{Day} 2005 r 3:30 **Physician** Margaret 0. Kenda11 April Ам /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hyattsville St. Thomas Moore Rehab. 9. Birthplace (State or Foreign New York, NY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 21, 1917 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🖼 F 045*09*7765 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County show ir items 23a or 28a-f shov diver reust be notified at 1 Yes 2 No Hvattsville MD Prince George's Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 4922 LaSalle Road 20782 death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or ite ury or other traumatic event, the Medical Examinal 1 Never Married 2 Married Specify White 1 ☐ Yes 2 ☐ Xo Specify Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: ģ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Receptionist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Coffey James O'Neill ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Riverdale Park, MD 20737 6115 43rd St. Linda Lundberg/ Family Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4/14/2005 Brentwood, MD Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Tunesal Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 segrand non 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardions iratory Arrest /Medical Due to (or as a consequence of): Examiner End Stare Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ➡No P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertention peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 ☐ Yes 2 ☐ No Yes 2Q-No 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3□ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury 5 Pending investigation 1-∰Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4/13/05 ac 00058290 alles MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Kumar Muttath, MD 4203 C 31. Date filed (Month, Day, Year) APR 1 4 2005 4203 Queenbury Road, Hysttsville, MD 20781 State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Man		artment rtificate			and M		giene	5 12712
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	/Medic Examir		4a. Fecility Name (If not institution, give	street and number)	CIL	4b. City, T RA1	NDA	Location o	STO	WN, A	4c. County o	Death SIMDICE
	Funeral Director		5. Social Security Number 6. Set 219-30-4385	X 7. Age (I	n yrs. last birthday, 84 Yrs.	Months	Days	If Under: Hours	Min.	8. Date of Birt	7920	9. Birthplace (State or Foreign Country) MD
	nyland how	_	10a. State 10b. County		Dc. City, Town or L	ocation						10d. Inside City Limits
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	h with		11 POMONA SOUTH	#5		101. Zip (COGO	2120)8		Tog. Citizen of ver	USA
	r deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decede	ent of His			city Yes or No- Rican, etc.)	14. Race	- American Indian, White, etc.
900	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28e-1 show he Modical Examinar must be notified at	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	NAVY	1 🗆 Yes 2		Specify:			Specify:	WHITE
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Mary	and and Is m		19a. Informant's Name/Relationship (Ty								r, City or Town, Si	
_	1 and Healt em 2 ther		GERALDINE KOMITZ 20a. Method of Disposition		20b. Place of Dispo	osition (Name	e of	1	-	ALIIMOF	RE, MD 21	L208 ity or Town, State
mo	e = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Dogation 5 ☐ Other (Specify)	lemoval from State	HAR SINA	matory or oth	ner place)4/13	/2005		SS MILLS, MD
Baltimore,	permit. Pag Department Importent: any injury o		21. Si Marifot Fundral Se file Ucan	uos	2	2. Name and	Address	s of Facility	y SOL	LEVINS	ON & BRO	
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Box 6	leath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of p							23d. Date	of delivery
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	To the within 2 To the complet	Med	29b. Signature and title proentier	and manner stated		29c.	License	number		2	9d. Date signed (Month, Day, Year)
}			/ Www	Kull			Do	391	D		4)11/1	05
	6		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	1001	724	e ^	1011	CCD : 301	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	RTHWES Signature	1 10	171	VITL	, LA	NUALL	NW 072	, ND
	Registr	. • .	APR 142	2005 Bleen	U JE A	porte	0					

		1	For State	State of Maryland		rtment of He			400	5 12713
			Registrar 1. Decedent's Name (First, Middle, Las	t)	007	imodio oi b		2. Date of Death		3. Time of Death
П	Physicia	an	John G. Langen					Month April		11.2044
	/Medic		la. Facility Name (If not institution, give			4b. City, Town, or I	Location of Death	F		
Н	Examin	er	844 North Shore			Glen Bu	rnie		Anne Ar	rundel
	Funeral		5. Social Security Number 6. Sec		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. E	Birthplace (State or Foreign Country)
	Director		212-36-0927	× 2□ F 66	Yrs.	World's Days	Tiodis Will.	Sept. 5	Reg. No. eath Day Year 8 2005 4c. County of Death Anne Arun rth Anne Arun rth 25,1938 10g. Citizen of What Coun Mary 10g. Citizen of What Coun Mary 10g. Citizen of What Coun Mary 16b. Kind of Business/In Meat Mercha a, Maiden Sumame) ischer ber, City or Town, State, Zig Burnie, Mary 20c. Location - City or Town Baltimore, tonsville, Mary arrest, 23d. Date of deliv Month 23d. Date of deliv Month 1 tobacco use contribute to to marrest, 23d. Date of deliv Month 23d. Date of deliv Month 23d. Date of deliv Month 25d. Date of deliv Month	aryland
	p ,	-	Usual Residence of Decedent 10a, State 10b, County	10c City	, Town or Lo	cation			Death Day Search 8 2005 4c. County of Death Anne Arun Birth Day, Year) 5,1938 10g. Citizen of What Cou U.S.A. 14. Race - Amer Black, White Specify: 16b. Kind of Business/I Meat Merch Die, Maiden Sumame) Fischer Inber, City or Town, State, Z Burnie, Mary 20c. Location - City or T Baltimore, Atonsville, Mary 20c. Location - City or T Baltimore, Atonsville, Mary 21 arrest, 23d. Date of delify Month 23d. Date of delify Month 16d tobacco use contribute to 17 yes 2 10 3 pro 18 yearest, 24b. Were au prior to cheath? 25 No 1 yes 26 No 1 yes 27 No 1 yes 28 No 1 yes 29 No 1 yes 29 No 1 yes 20 No 1 yes 21 No 1 yes 22 No 1 yes 23 No 1 yes 24b. Were au prior to cheath? 25 No 1 yes 26 No 1 yes 27 No 1 yes 28 No 1 yes 29 No 1 yes 20 N	10d. Inside City Limits
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	he M	Director	Maryland Anne Ar	under	GTEII	10f. Zip Code		10	g. Citizen of What	Country?
	a or		844 North Shore	Defino		21060)			
	eath	era	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-	14. Race - A	merican Indian,
10	r iten	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No				Rican, etc.)		hite, etc.
93	alf, o	þ	3 ☐ Widowed 4 反 Divorced	ff Yes, Give Year or Dates:		1 □ Yes 2 ⊠ No	Specify:		Specify:	White
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2	led w lygier her th		47 Falbaria Nama (First Middle Loct)	2+	Self	Employed	18 Mother's Name			cnant
Maryland 21215-0036	be fi	m	17. Father's Name (First, Middle, Last)					- (,	· ·	
2	J Mer narke	2	George Langenfe		19h Mailir	ng Address (Street a				e. Zip Code)
Na	d 2 st th and 7 is r traur	- 38	John S. Langenfel							
Ġ,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinet must be notified all and once.		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	! [The state of the s		
nor	ages int of t; if it		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State		natory or other place ark Cemete	1	-2005	Raltimor	e Marvland
Baltimore,	ortan injur	I	21. Signature Juneral Service Licer		22	Name and Address	s of Facility			
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of V	8 S B	To E	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie		4 Nursing no			Specify)
n o			27. Manger of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	ς?	28d. Describe ho	w infury occurred	
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	Hos 24 hc Fun etely	edical	(Check only one) Medical Exa	miner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my or	pinion, death occur	red at the time, da	ate and place, and	due to the cause(s)
	To the I within 24 To the I complete	Me	29b. Signature and title of certifier	11	λ,	29c. License	e number	29	d. Date signed (M	onth, Day, Year)
	- × - 0		Comt	~ M	V	Y	3904		Hpril	11 2005
	1,		30. Name and address of person who	completed cause of death (Item	n 23a) (Type	Print)	205	Hai	pita	Drivo.
	10		GATATR	Mun	MAC	ADDA	3)	Jen B	ine	[MD STOP]
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	Regist	rar	APR	1 4 2005 Block	U B.	Gover				

			For State Registrar	State of I	Maryland		artmen rtificat			and M		giene Reg. No	2001	5 1271	
	Physicia	an	Decedent's Name (First, Middle, Donna	, Last)	Jean		La	wton			2. Date of De. Month	Day			:h
	/Medic		4a. Facility Name (If not institution,	rive street and numb					Location o	of Death	4	11	200 County of D		
	Examin	er	Johns Hopkir				4b. Oity,		timor			46.	N.		
	Funeral			6. Sex 7.	Age (In yrs. la	ast birthday)	If Under	1 Year	If Under		8. Date of Birt (Month, Da	h Vaar)	9. 1	Birthplace (State or Ford Country)	eign
	Director		213-70-1519 Usual Residence of Decedent	1□M 2 X F	47	Yrs.	Months	Days	Hours	WIII.	4-16-			Md.	
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ā	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationsh Michael T. Lav		Son						Baltir			e, Zip Code) 21214	
altimore,	0 0		20a. Method of Disposition 1 \$\sum_{\text{E}}\text{urial} 2 \$\sum_{\text{Cremation}}\text{Cremation} \\ ^4 \$\sum_{\text{Donation}}\text{Donation} 5 \$\sum_{\text{Other}}\text{Other}(Sp)			ace of Dispo metery, crer)	4–16	ate			or Town, State	
붍	permit. Pag Depertment Importent: i any injury o		21. Signature of Funeral Service L		110		2. Name an		s of Facilit				nore, 1		_
m	Per Imp any any		1 Glade	pho	نسفس		March	F.H	. Eas	Ł			North		
3760,	death certificate be executed e attending physicien and for use as the burial-transit	lical Examiner	23a. Part1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a conseque	ence of): Studence of): Compared to the content of the content o	s 'u	My	va	7:	1	jer,	J	Approximate Interval Between Onset and Death 2 - 3 ft	a
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ds, P.	luires that the de is signed by the signed by	by	Part II. Other significant condition	ns contributing to deat	h but not resul	iting in the u	nderlying c	ause give	n in Part I.		23e. Did to		at .	to the cause of death?	- 4
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed									24a. Was autop perfor	sy	24b. Were prior to death		ble of
Vital	Physicien: Th this certificate ral director, pag	Be C	25. Was case referred to medical						26. Place	of Death	(Check only o		, , , , ,	65 2 140	
	hysic his ce I dire	To	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp.	atient 200	R/Outpatien	it 3□ DC	A Othe	r: 4 🗆 Nu	rsing Hor	ne 5□Resid	lence (Other (S	pecify)	
Division of	ding After fune		27. Manner of Death 1 Natural 5 Pending investigation	ation	njury Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 Y	at ? ′es 2 □ ľ		28d. Describe h	iow injur	y occurred		
DIX	P Sign	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 289. Place of	Injury - At hon , etc. <i>(Specify)</i>	ne, farm, str	eet, factory	, office		2	28f. Location (5 City or Tox	Street and m. State	d Number or	Rural Route Number,	
	To the Hospitel or within 24 hours efter to the Funerel Dir completely filled in I	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminar: On the basi and manner	s of examination	rledge, death on and/or in	h occurred vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ded at the time, o	cause(s) date and	and manner place, and d	as stated. lue to the cause(s)	
	To the To the complet	Σ	29b. Signature and title of certifier	man	1/2	>	290	License	number	10		29d. Dat	signed (Mo	onth, Day, Year)	
6	5			1/11				1)	50	110	2	. [119	105	
5			30. Name and addres of person	mpleted cause of	of death (Item:	23a) (Type,	Print)		23	23	192	pa	Ms S	1	
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signatu	ure,	poek	Þ		Ba	et me	re	ma	2/224	_

		•	For State Registrar	State of M	laryland / D		ent of Hea		_	iene 19. No. 005	12715
	Physici		1. Decedent's Name (First, Middle, Last Charles M		ırkiewicz				2. Date of Deat		3. Time of Death 11:30a M
	/Medio Examir		4a. Facility Name (If not institution, give Joseph Richey Hos		7)	4b. C	ity, Town, or Lo Baltin	ocation of Death		4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Security Number 213-32-0637	X 7. A	ge (In yrs. last birth	day) If Ur Mont		f Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, AUG 30,	^Y °°1'935 Ma	irthplace (State or Foreign Country) Iryland
		ior	Usual Residence of Decedent 10a. State 10b. County Maryland Baltir	more	10c. City, Town		onsvil]	le			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23s or 28s-	al Director	10e. Street and Number 102 South Roll:				Zip Code 21228		10	Og. Citizen of What (Country?
980	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-1 show na Madical Exemiliar must be indiffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Pyes 2 If Yes, Give Year or Dates	? 1953-	If Yes,	specify Cuban,	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
21215-0036	be filed within 72 hours aft ntal Hygiene. sd other than "natural", or event, tre Medical Exemi	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or	(54)	Decedent's l Give kind or life. DO NO Dlicer		on ring most of workir	ng	Baltimore Police De	City
Maryland 2	should be filed and Mental Hygis marked other umatic event, It	To Be C	17. Father's Name (First, Middle, Last) Max Markiewicz				I	Blanche	Unk		
	s 1 and 2 should of Health and Meritam 27 is marke other traumatic		19a. Informant's Name/Relationship (T) Marion Markiewicz		102	2 Sout	h Rolli	ing Road	Catons	City or Town, State, SVIIIe, MD	21228
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signatural of Funeral Service Disease		20b. Place of I cemetery Metro (Cremat	ory, Ir	10.4/15	5/05	Baltimore	e, MD
Ba	permit. Departn Imports any in[s		Thomas Gregor		ad the death. Do no	299	Frederi	ick Road	Baltim	and, Inc. ore, MD 2	
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or compositors, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or a	line. Com Domo s a consequence of	~ 69):	Lir		netas		Interval Between Opset and Death
8760, <	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of):					
O. Box 6	that the death certific led by the attending p detached for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ∐Fetal death at time of death	3 ☐Ectopi 5 ☐ Other	c pregnancy (specify)			23d. Date of do Month	elivery Day Year
σ.	n requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death	but not resulting in	the underlyin	ig cause given i	in Part I.	23e. Did tob		to the cause of death? Probably 4 □Unknown
al Records,		Completed							24a. Was an autopsy perform	prior to led/2 death?	autopsy findings available completion of cause of s 2 \sum No
Division of Vital	Attanding Physicien: Th ir death. actor; Atter this certificate by the funeral director, pag	Certification; To Be	27. Manner of Death 1 Natural 5 Pending investigation	1 □ Inpat 28a. Date of In (Month, D	jury 28b. Tii ay Year) Inj	me of ury M	DOA Other: 28c. Injury at Work? 1 Yes	s 2 No	ne 5 Resider	nce 6 Other (Sp w injury occurred	ne f
Divi	ital or Attanours after deathurs after deathurs ral Diractor;		4 Homicide determined	building, e	njury - At home, farr etc. (Specify)				City or Town,		
	To the Hospital or At within 24 hours after d To tha Funaral Diract completely filled in by	Medical			of examination and			ion, death occurre	ed at the time, da	use(s) and manner a te and place, and du ld. Date sighed (Mo)	re to the cause(s)
)	T wit				4		DI	257	2	4/14/	2005
	841		30. Name and address of person who could be seen and address of person address	L155	trar's Signature	ype, Print)	tani	U Ka	1 #3	15 15 al	H MD 21210
	Sta Registi			005	ve #	freed	U				

Charles MARKiewiez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 2:15 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bal beth ente 120 SIMA imore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 30,1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 対 M 2 □ F Yrs. Director Washington D.C 577-07-2152 86 Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ite Medical Examinat minust be multiled at 1 Yes 2 □ No Directo Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21229 USA 251 South Morley Street death Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic exercises." 12. Was Decedent Ever in U.S. Armed Forces? 1 13 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Religious 5+ Roman Catholic Priest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Nichols Jeremiah J. McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 251 South Morley Street; Baltimore, Maryland 21229 Fr. William Murphy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/14/2005 * 4 □ Donation 5 □ Other (Specify) New Cathedral Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician men V-ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner e avs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be wordism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No mia certificate has 2 No 1 Yes tuneral director. 25. Was case referred to medical Be 26. Place of Death (Check only one. Other: 2 No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) he Hospital or Attending PI n 24 hours after death. he Funeral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ၀

State Registrar 30. Name and address of person who complete voluse of death (Item 23a) (Type, Print)

18-01150n

3

31. Date filed Month, Day, Year)

10:40

PRIL

			For	State of N							•	ene,	
			For State Registrar			Cei	tificate	of D	eath		Re	g. No UU	12718
ı	Physicia	an	1. Decedent's Name (First, Middle, Las	•							Date of Death	Day Yea	
	/Medic	al	Mary Kathleen M				th Ob. T				pril l	1, 2005	5:59 A ^M
	Examin	er	4a. Facility Name (If not institution, give Shady Grove Adver				4b. City, To Rock			Death		4c. County of De	
	Funeral		5. Social Security Number 6. So		Age (In yrs. I	last birthday)	If Under 1	Year	If Under 2	4 Hrs. 8. C	ate of Birth	Montgo 9. E	irthplace (State or Foreign Country)
ı	Director		338-26-2678	□M 2፟A F	72	Yrs.	Months [Days	Hours	Min. Ja	Month, Day,	1933 I	llinois
	pu ≱ ∴		Usual Residence of Decedent 10a. State 10b. County		10c City	/. Town or Lo	cation						10d. Inside City Limits
	Maryla f sho	ō	Maryland Montgom	orv	,	Rockvi							1⊠Yes 2□No
	r 28e-	rect	10e. Street and Number	ery		ROCKVI	10f. Zip C	ode	-		10	g. Citizen of What	Country?
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show to Marical Ezainii at must be multiled at	Completed by Funeral Director	2282 Dunster Lane				2	2085	4			United St	ates
	r dea	ner	11. Marital Status	12. Was Decede Armed Force	s?	S. 13.	Was Deceder f Yes, specify	nt of Hisp Cuban,	panic Origi Mexican,	in? (Specify Puerto Rical	Yes or No- n, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Date			1 ☐ Yes 22		Specify:			Specify: V	Thite
21215-0036	2 hour	ed t	15. Decedent's Ed	ucation	-	16a. Deced	dent's Usual (Occupati	ion		1	6b. Kind of Busines	s/Industry
215	thin 73	ple	(Specify only highest gra	de completed) College (1-4d	or 5+)		kind of work OO NOT use			of working			
2	ed wil	Соп		4		Lab Cl	nief S						Government
and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)					1				aiden Sumame)	
Maryland	hould de Mei	으	Henry Grace 19a. Informant's Name/Relationship (7)	(vne Print)		19h Mailir	na Address (S	Street an		ille N		City or Town, State	Zin Code)
	ulth an 27 ls rtreu		James W. McMahor										20854
re,	othe		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	of		Date	2	0c. Location - City	
Ē	Page nent c ant: If		1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify			ocký G eran's			1	April 2005	18,	Cumberlan	d, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumetic event, the Marildal Examinating must be radiified at once.		21. Signature of Funeral Service Licen	6		Ro	bert A.	Address Pum	of Facility phrey	Funeral	Home/I	Rockville,	Inc.
	EG 2 6 0		23a. Part1. Enter the disease, or comp		01420								Land 20850–2805 Approximate
5			shock, or heart failure. List only a Immediate Cause (Final	one cause on each	line.)45C	1. +	- 0			pilatory arros		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	-	nyw	VM	14				
П	Examiner		Sequentially list conditions	b									
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V	xecut and al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or	as a consequ	uence of):							
8760,	ate be executed hysician and the burial-transit	cal E		d									
9	rtifical ng phy as th		IF FEMALE:									71	
Box	death certifics attending phase as t	lan/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	2 🗌 Fetal	death 3	Ectopic preg	nancy				23d. Date of o	elivery Day Year
P.O. I	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnant 9□Unknowr		eath 5□	Other (spec	ify)				14101181	bay roar
	res that the de signed by the a be detached f	y Ph	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the ur	nderlying cau	se given	in Part I.		23e. Did toba	acco use contribute	to the cause of death?
rds	w requires been sign should be	ed by	Parkinson's	Dise	9se						1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown
Records,	e law re has bee je 2 sho	Completed	Chronic Obst	ructive	Pulm.	ongry	DIS	691	e		24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
Ě	The ate har page	Com			Ì	/					perform 1 🗌 Yes 2	ed? death	
Viita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:						of Death (Ch	eck only one,)	
of	Phyer this cral dir	5	1 Yes 2 No 27. Manner of Death	1 🗆 Inpa		ER/Outpatien 28b. Time of	The second second	Other:	4 Iquis			nce 6 Other (Sp vinjury occurred	pecify)
on	Attending ir death. ector: After by the fune	tlon	1 ■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of le (Month, I	Day Year)	Injury	М	. Injury a Work? 1 🗌 Ye	s 2 □N				
Division of Vital	er dea rector by the	Certification:	3 Suicide 6 Could not be determined	289. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, c	office		28f. L	ocation (Stre	et and Number or . State)	Rural Route Number,
	Hospitel or thours after Funerel Dir tely filled in												
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1	ysician: To the be liner: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred at restigation, in	the time my opir	, date and nion, death	place, and on occurred at	the time, dat	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				_	icense r)	290	d. Pate signed (Mo	nth, Day, Year)
,	9		runc					388	54.	1	14	11102	
	10		30. Name and address of person who of David Klein, M.D.,				•	. Ro	ockvi	11e. M	larv1ar	d 20850	
	Sta Registr		31. Date filed (Month, Day, Year) APR 14	32. F ag i	strar's Signat	ture	and a			-, -,	, 201		
						-							

		ı	For State Registrar	State of I	Marylan		artment of tificate o		and Me	_	giene Reg. No	C U U	5	12719
			1. Decedent's Name (First, Middle, L	ast)					2	2. Date of De		v V		3. Time of Death
	Physici /Medic		I533C	Gray	•	McGn	ee			April (Day 13	, 200	ar	5:15 A M
	Examin		4a. Facility Name (If not institution, gr	ve street and number	er)		4b. City, Town	n, or Location of	of Death		4c.	County of E	Death	
		•	Corroll	Hospita	1 Con	yer	1	westn	nmst	Ry		(3	rol	\
	Funeral Director		5. Social Security Number 6. 219–10–3334	Sex 7. 1 XM 2 ☐ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da		Min.	B. Date of Bir Month, 2a	th Y, Y139	21 ^{9.}	Birthpla Count CN1	ace (State or Foreign
	PC ,		Usual Residence of Decedent		10.00									
	arylau show	Ļ	10a. State 10b. County			ty, Town or Lo							10	d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	cto	Maryland Carrol	1	Ma	anchest				-				
	or 2	Director	10e. Street and Number				10f. Zip Cod				10g. Cit	izen of Wha		ry?
	ath v		4242 Falls Rd.					102				U.S.		
	tems	Funeral	11. Marital Status	12. Was Decede Amed Force	s?	.S. 13. \	Was Decedent of Yes, specify C	of Hispanic Original Suban, Mexican	gin? (Speci i, Puerto Ri	ify Yes or No ican, etc.)	-	14. Race - A Black, V		
36	s afte	by F	1 ☐ Never Married 2 🐧 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give	_ No		1 □ Yes 2 🔏	No Specify:				Specify:	1	White
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Examirae must be multifed at		15. Decedent's E	Year or Date	S:	I 16a Docor	dent's Usual Oc	ourstice.			165 K	ind of Dunin		
ਨ	n 72 i "na"	lete	(Specify only highest g	rade completed)		(Give	kind of work do DO NOT use re	ne during most tired)	t of working	7	16D. K	ind of Busine	essvinai	istry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		rpente				Co	onstru	cti	on
9	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, Ite Mudical Examinat must be rediffed at	a)	17. Father's Name (First, Middle, Las	t)			AI POII OG		r's Name (First, Middle,	Maiden	Sumame)		
Maryland	Mental arked o	To B	John Decatur	McGhee				М	vrtle	Ethel	. Wil	lson		
37	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship			19b. Mailin	g Address (Str						te, Zip (Code)
$\mathbf{\Xi}$	od 1 lith a 27 ls		Sylvia M. McGhee	- wife		4242	Falls 1	Rd. Man	chest	er. Md	1. 2	1102		
ē,	ss 1 and 2 of Health item 27		20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of	1	Da			cation - City	or Tox	n, State
UO	ages ant ol it: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec				natory or other in FreeW:		tist	Ch. C	m.	ierson April	16.	A. 2005
altimore,	artme orten in ur		21. Signature of Funeral Service Lice	•			. Name and Ad			011.		_		mil Dr.
Ba	permit Pages 1 Department of H Importent: If ite any in ury or ot once.		J. Hath Ell	S		Ec	khardt	Funera	1 Cha		A. 1	Manche	ste	r, Md. 2110
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caus y one cause on each aa	sed the deati		er the mode of		cardiac or	respiratory a	rrest,		1	Approximate interval Between Onset and Death
	Examiner		1	Due to (or	as a conseq		A	10.0007	wino.	· 2 ·			-	
î.		7	Sequentially list conditions,	b. Due to for	as a consad	2 2 4 v 3	()	deno (2	A Clubs	1) 6			4	- Limil N.Z
Γ	ted nsit	Examiner	Cause (Disease or injury											
_	al-tra	хаг	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):				_			-	
8760,	cate be executed physician and the burial-transit	dlcal		4										
687		edlo		d.										
Box	death certifi e attending id for use as	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor							;	23d. Date of	deliven	,
ă	death a atte	Physician/M	in the past 12 months?	1□Live birth 4□Pregnan			lEctopic pregna] Other <i>(specify</i> ,					Month)ay Year
o.	that the de ed by the detached	hys	9 Unknown	9□ Unknowr	1									
م ٔ	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to death	n but not res	ulting in the ur	nderlying cause	given in Part I.		23e. Did to	obacco u	ise contribut	e to the	cause of death?
rds	quires n sign									1 🗆 1	/es 2[□No 3□] Probal	oly 4° Unknown
Records,	> 0 0	Completed								24a. Was	an	24b. Were	autops	sy findings available
æ	0 - 0	E			-					autop perfo	rmed2	prior	to comp	pletion of cause of
Vital	icien: Th certificate ector, pag	ပို	25. Was case referred to medical					26 Place	of Dooth /	1 Yes	2 No	1 1	Yes 2	ENo .
>		0 8	examiner? 1 Tes 2 No	Hospital:	atient 2	ER/Outpatien	t 3 DOA	Other		5 ☐ Resid		6 DOther /	Spooifu)	
of		-	27. Manner of Death	28a. Date of I	njury	28b. Time of	28c. Ir	njury at		d. Describe h			эрөспу)	
O	th. : Afte	100	1 Natural 5 Pending 2 Accident investigate		Day Year)	Injury		Work? □□Yes 2□1	No					
Division	l or Attending after death. Director: After in by the fune	fice	3 ☐ Suicide 6 ☐ Could not	286. Place of	Injury - At ho	ome, farm, stre	et, factory, offic	ce	28	f. Location (S	Street an	d Number o	r Rural I	Poute Number,
ă	el or A	Certification;	4 Homicide	building,	etc. (Specify	y)				City or Tox	m, State)		
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying P	hysicien: To the be	st of my kno	wledge, death	occurred at the	e time, date and	d place, an	d due to the	cause(s)	and manne	r as stat	ed.
	n 24 n 24 ne Fu	edical	(Check only 2 Medice! Exe	miner: On the basis and manner	s of examina	ition and/or inv	estigation, in m	y opinion, deat	th occurred	at the time,	date and	place, and	due to ti	he cause(s)
	To the twithin 2. To the Complet	Me	29b. Signature and title of certifier	, /				ense number			29d. Dat	e signed (M	onth, Da	ay, Year)
)			Not.	M Mel	MAS		1	PP200C	143		Ar	11 / 100	3, 7	2002
	Λ		30. Name and address of person who	completed cause of	of death (Item	n 23a) (Type,	Print)							
	6		John (. Asel M	10 295	5700	ner Ava	Print)	P 307	M52	funins	ter,	MK	2	1157.
	Sta	te	31. Date filed (Month, Day, Year)	2005 32. Egi	strar's Signa	atural d	and I							
	Registr	ar	APR 14	2005	Electric .	~ 7								

			1 - For State Registrar		Maryland		artment ortificate			nd Mental	Reg.	Time &	05	127	20
	Physici	an	1. Decedent's Name (First, Middle, Dolores M.	Last) Neville						2. Date	1	Day	Year	3. Time of	
	/Medic	al	4a. Facility Name (If not institution,		or)		4b. City, To	wn orloa	ration of C	Apr	<u>i1</u>	11,	2005 inty of Death	3:05	Р.м
	Examin	er	Frederick Vill			b		nsvil		2 0 atri			ltimor		
	Funeral			6. Sex 7	Age (In yrs. la		If Under 1	rear If	Under 24	Hrs. 8. Date of	of Birth h, Day, Ye			place (State o	r Foreign
	Director		218-12-6750	1 □ M 2 131.F	86	Yrs.	MOTHES	ays II	louis	July	6,	1918		yland _	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside Ci	tv Limits
	Many -f sho	to	Maryland Baltim	ore	Car	tonsv:	1110							1 ☐ Yes	-
	th the or 28a a notifi	Directo	10e. Street and Number	OIC	Ua_	COMSV.	10f. Zip Co	ode			10g.	Citizen	of What Cou	intry?	
	23a c											USA			
	er des	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	- 13.	Was Deceden If Yes, specify	t of Hispar Cuban, M	nic Origin Iexican, P	n? (Specify Yes of Puerto Rican, etc.	or No-		Race - Amer Black, White		
36	irs aft	by F	1 ∑Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □Yes 2 [If Yes, Give Year or Date:			1□Yes 2万	No S	pecify:			Spe	ecify: W	hite	
ŏ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ant, the Madical Examinar must be notified at	ted	15. Decedent's	Education		16a. Dece	dent's Usual (occupation	1		168	o. Kind o	f Business/li	ndustry	
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	kind of work of DO NOT use	retired)	g most of	r working					
2	Hygier Hygier her th	ပိ	12 17. Father's Name (First, Middle, L	antl		Cler	K	10	Mathada	Name (Circle 14			al Sec	urity	
and	d be fantal H) Be	Joseph Neville	151)				18.		Name (First, M.) Gosne1		aen Sun	пате)		
ar Z	should be and Mental s marked o umatic eve	2	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (S	treet and I		or Rural Route N		ity or To	wn, State, Zi	p Code)	
ž	and 2 salth a n 27 ls		Anne M. Heinlei	n	Niece	1113	Bellev	rista	Cou	rt; Seve	erna	Parl	k, MD	21146	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural, or items 23a or 28a-1 show or other traumatic event, the Madical Exerciper mat Le notified at		20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 Demoval from Sta	rer.	nce of Dispo	nsition (Name matory or othe	of r place)		Date	200	c. Location	on - City or T	own, State	
Ĕ	. Pages tment of I tant: If it		*4 ☐ Donation 5 ☐ Other (Sp.	ecify)	New	_/				4/13/05	Ва	1tim	ore, 1	Marylan	ıd
Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 li any injury or other tra	10	21. Signature of Funeral Service L	Censee	veste	2	Sterl: 736 Ec	ing A	shto	n Schwal Avenue;	Fun Cato	eral nsvi	Home	, Inc.	28
H.			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caus nly one cause on each	sed the death.	Do not ent	er the mode o	f dying, su	uch as car	rdiac or respirate	ory arrest,			Approximate Interval Bety Onset and D	een Neen
i i	Pnysician /Medical	i la	Immediate Cause (Final disease or condition resulting in death)	a	ta	ilu	re :	DO	In.	nve				Onset and L	764(1)
	Examiner			Due to (or a	as a consoue	ence of):	22 0	200							
	1000	jer	Sequentially list conditions, factorial to the cause. Enter Underlying Cause (Disease or injury	b. Due to (or :	as a conseque	nou uf):	15 22	(0.					- 11		
le"	cuted	Examiner	trial initiated events	c.											
Ö,	cate be executed obysician and the burial-transit	Exa	resulting in death) Last	Due to (or a	as a conseque	ence of):									
8760	physic the b	dlcal		d											
9 X C	death certifica e attending ph od for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon								23d	Date of deliv	erv	
Box	death e atter d for u	iciar	in the past 12 months?	4□Pregnant	2 ☐ Fetal d at time of dea		Ectopic pregi Other (speci						Month		'ear
0	at the by the	hys	9 Unknown	9□ Unknown	1										
	The law requires that the de ste has been signed by the a page 2 should be detached t	by	Part II. Other significant condition	s contributing to death	n but not result	ting in the u	nderlying caus	e given in	Part I.			_		he cause of de	
ord	w require been significant	eted									1 ☐ Yes	2 🗆 No	3 Pro	bably 4	nknown
Records,	e law has b	Completed								_	Was an autopsy perform a d			opsy findings a empletion of ca	
Vital		e Co	25 Was soon referred to medical							1 🗆 Y	es 2	No		2□ No	
	Physician: this certifica	0 0	25. Was case referred to medical examiner?	Hospital:	atient 2 FI	R/Outpatien	t 3 DOA	Other:	<u></u>	Death Check of ng Home 5		a 6 🗆 (Other (Speci	64)	
Division of	iding Phy th. : After thi : funeral c	L:U	27. Manner of Death	28a. Date of Ir		8b. Time of		Injury at Work?	Lations	28d. Desc				(4)	
200	uttendin death. ctor: Afi y the fur	atlo	Natural 5 Pending investiga	ition	bay roury	Hijary	М	1 Tyes	2 🗌 No						
<u>S</u>	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place of	Injury - At hom etc. (Specify)	e, farm, str	eet, factory, o	fice			on (Stree r Town, S		mber or Run	al Route Numb	er,
	pital purs a eral D	Ce	29a. Certifier	Physician To the he	at of my knowl	ladaa d		h = 41== = =d			45	4.			
	To the Hospital or Attending Physician: whim 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical		Physician: To the be- xaminer: On the basis and manner	of examinatio	n and/or in	vestigation, in	my opinio	n, death o	occurred at the t	me, date	and plac	manner as s e, and due t	stated. o the cause(s)	
	To the Hospital within 24 hours a To the Funeral C completely filled	Me	29b. Signature and title of certifier	14.7	o . h .	k.i	_	cense nur				t.	ned (Month,		
1	5		Ktorner	ly AH	endiv	3 M	り	250	30	3		41	12/0	1	
	1X	8	30. Name and address of person w			23a) (Type,	Print)	CF.	۔ ۵ م	nou n	Λ .	1 .~	11.2	01	2
	Sta	10	31. Date filed (Month, Day, Year)	1-GCN Pr	strar's ignatu	19 MO	40	7 11	r au	nux 1	a S	14C	102	2122	-3
	Registr		ÁÞ	R 1 4 2005	Malu	ر م	· Aps	de)							

Physicia /Medic Examin

Funeral Director

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.													
	For		State of Ma	aryland / [Оера	artment of H	lealth and M	Mental Hyg	jier	enne	10701			
	1 - State Registrar				Cer	tificate of l	Death	F	leg. N	to.	16/61			
	1. Decedent's Name	(First, Middle, La	st)					2. Date of Dea			3. Time of Death			
in al	Pau	1 A.	Niegsch					April		11, 200!				
er		-	e street and number)				Location of Death	1	4	lc. County of De				
	Oak Cres 5. Social Security Nu			e (In yrs. last birt	thday)	If Under 1 Year	ville If Under 24 Hrs.	8. Date of Birth			more Co.			
	216-20-3		M 2□F		Yrs.	Months Days	Hours Min.	Nov. 26	, Yea	(r) (irthplace (State or Foreign Country) aryland			
	Usual Residence of							1100. 20	,	IJZTI NO	ar y rand			
-	10a. State	10b. County	0	10c. City, Town							10d. Inside City Limits			
ecto	Maryland		more Co.	Par	rkv	ille					1 ☐ Yes 2 ☑ No			
	10e. Street and Num			100		10f. Zip Code	1004	1		itizen of What C				
ra	8810 Walther Blvd. Apt. 3122 21234									United S				
une	11. Marital Status 1 ☐ Never Marrie	ad 0 V 1.84aasiad	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		14. Race - Am Black, Wh				
Completed by Funeral Director	3 Widowed		1 (A) Yes 2 (1) If Yes, Give Year or Dates:		1	☐Yes 2☐XNo	Specify:			Specify:	Mhite			
ted	(2)	15. Decedent's Ed	ducation		Deced	ent's Usual Occupa	ation		16b.	Kind of Busines				
npie	Elementary/Secon	fy onfy highest grandary (0-12)	College (1-4or 5	5+)	life. D	kind of work done of OO NOT use retired	luring most of work)	king						
် ပ	12		4 yrs		Ac	ccountant				Account	ting			
Be	17. Father's Name (i						18. Mother's Nam			en Surname)				
Paul H. Niegsch Dorthea Volker											State Zin Code)			
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruth J. Niegsch / Wife 8810 Walther Blvd. Apt. 3122 Parkville.MD 21234														
	20a. Method of Disp		scii /wiie			walther sition (Name of		pt. 3122 Date	_	Location - City o	le, MD 21234			
	1 🛚 Burial 2	Cremation 3	Removal from State	cemeter	y, crem	atory or other place	9)							
		5 ☐ Other (Specifineral Service Licer	yoo Michael			Lutheran Name and Addres		14/2005			e, Maryland			
	Mis	OC.C.	7-/-	L. Canapp			J. Ruck.	Inc.		05 Harfo Itimore.				
	23a. Part1. Enter th shock, or hear	e disease, or com t failure. List only	plications that caused one cause on each lin	I the death. Do n	ot ente				est,		Approximate Interval Between			
	Immediate Cause (F	Final	000.	MINO	in						Onset and Death			
	resulting in death)		Due to (or as	a consequence o	of):						1995			
_	Sequentially list con	ditions,	b											
lue	if any, leading to imposure. Enter Under	mediate lying	Due to (or as	a consequence o	of):									
Examine	that initiated events resulting in death) Li		c. Due to (or as	a consequence o	of):									
- 1		- L			,									
ed			d											
cian/Medica	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome		• •					23d. Date of de	elivery			
Sicia	in the past 12 n 1 Tes 2		4☐Pregnant at	2 Fetal death time of death		Ectopic pregnancy Other (specify)				Month	Day Year			
Fnys	9 🗆 Unknown													
	Part II. Other signific	cant conditions c	ontributing to death be	ut not resulting in	the un	derlying cause give	n in Part I.			_	o the cause of death?			
ted	MINIM	n reu	ological !	COLLA	11 (opin!		1 🗆 Ye	es 2	2 No 3 P	robably			
completed by	CAD							24a. Was a autops	V A	24b. Were a prior to	utopsy findings available completion of cause of			
-								perform 1 Yes	ndd? □N	_ death?	/			
e C	25. Was case referre examiner?		Hospital:			Otho	26. Place of Deat	h Check onl on	е		127			
0	1 ☐ Yes 2 ☐ N 27. Manner of Death	10	1 ☐ Inpatie				4 rsing Ho	ome 5 Reside			ecify)			
Ĕ	1 Deliveries	5 Ponding	(Month, Day	Year) In	iurv	28c. Injury Work	?	28d. Describe ho	w inji	ny occurred				

use as the burial-transit cate has been signed by the attending physician and page 2 should be detached for use as the burial-trai within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Medical Certification

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

29a. Certifier (Check only one)

1 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Injury Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and little of certifier

29c. License number J-3 115 29d. Date signed (Month, Day, Year) 2005

30. Name and address From who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Montphy 124 2005

32 Tegistrar's Signature

B1-8

Parientle mo 21234

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND TTEM Middle, Las PER FH G842 Qertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Deanna DEANNA NEHRING 2:41 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore City Unversity of Mayland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 8-1-1934 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 70 213-30-8900 Yrs. Director MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. It a Madical Examinat must be notified an once. MD Glen Burnie Anne Arundel 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 Ferndale Ave. 21061 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) OWN HOME Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vernon Norris Elizabeth Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Sarah Nehring/daughter 26 Ferndale Ave., Glen Burnie, MD 21061 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4/12/2005 | Stevensville, MD Chesapeake Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Livensee M01364 1 Second Ave Sw Glen Burnie MD 21061 mis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician remarchagic Stroke /Medical Due to (or as a consequence of): Examiner autropagation for atrial thrembi 10 days Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit atrial fibrillation and Due to (or as a consequence of): Box 68760. igned by the attending physician be detached for use as the burial mitral Stenosis Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ bevascular accordant cate has been signated bage 2 should b 1 ☐ Yes 2 ZNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C cal JE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 11, 2005 15859 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 South Robert Davidson Baltomore, Many and 22 Street 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

4 2005

		1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	rtificate o			eg. No:- 0 0	5 12723
Physic	ian	1. Decedent's Name (First, Middle,		=			2. Date of Deat Month	Day Ye	3. Time of Death
/Medi	ical	HERMAN 4a. Facility Name (If not institution,		ORGE		VASDOR , or Location of Death	APRIL	11 2005 4c. County of E	
Exami	ner	HOSPICE OF BALT		RIST CTR.	vo. oxy, roun	TOWSON		,	LTIMORE
Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Yea Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day) 04/19/1		Birthplace (State or Foreign
Director		213-12-6394 Usual Residence of Decedent	TASIMI ZLIF	91 Yrs.			04/19/1	913	POLAND
yland yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or teme 23e or 28e-f show event. The Medical Examinar must be notified at	Funeral Director	MD BALTI	MORE	TIMONIUM				· · · · · · · · · · · · · · · · · · ·	1 ☐ Yes 2 ☑ No
with th	Dire	10e. Street and Number	DOAD #101		10f. Zip Code		1	0g. Citizen of Wha	
me 23e	erai	12200 BURNCOURT	12. Was Decedent 8 Argoed Forces?	Ever in U.S. 13.	21093 Was Decedent o	Maria Prigin? (Spuban, Mexican, Puerto	ecify Yes or No-		American Indian,
or Iter	by Fun	1 Never Married 2 Marrie	d 1 (∆ Yes 2 □ N If Yes. Give	lo l	If Yes, specify Ct		Rican, etc.)	Specify: W	White, etc. YHITE
tural"	ed b	3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occ	unation		16b. Kind of Busin	
Medis	piet	(Specify only highest	grade completed) College (1-4or 5	(Give	kind of work dor DO NOT use reti	ne during most of work ired)	king	•	,
ygiene ver the t. the	Completed	Elementary/Secondary (0-12)		EXEC	UTIVE			G & D IN	MPORTS
and Mental Hygi Is marked other eumetic event,	Be	17. Father's Name (First, Middle, L	ast)	NASD	ΔD	18. Mother's Nam	e (First, Middle, I		CNDOVITZ
mark	2	MAX 19a. Informant's Name/Relationsh	p (Type, Print)			MAL et and Number or Rui	ral Route Number		RENBOVITZ te, Zip Code)
12 Tr		MARY PATRICIA NA			O BURNCO	OURT ROAD	#101 TIM	ONIUM, ME	21093
If item or othe		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation		BETH YER KURLAND	osition (Name of ODA)	(ace) 04/1		20c. Location - City ROSEDALE	
Department of I Importent: If its any injury or o occe.		' 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Fure → Sprvice L	- Carter		2. Name and Ado			ON & BROS	
any one		/ and		11 -25		30			E, MD 21208
Physician /Medical /Medical special /Medical /Medical /Medical /Medical /Medical	Examiner	23a. Part 1. Enter 1. disease, 1. c. shock, or heat failure. Set of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence of): a consequence of): a consequence of):	Denos	nta			Onset and Death
	dicai		d						
ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 (□Ectopic pregnar □ Other (specity)			23d. Date of Month	f delivery Day Year
g ag	b	Part II. Other significant condition	s contributing to death bu	ut not resulting in the u	inderlying cause	given in Part I.	23e. Did tob	1 /	te to the cause of death? Probably 4 Dunknown
rate has been signed by the attending phyage 2 should be detached for use as the	Completed						24a. Was a autops perform	mpd? prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		10	7th a=	th (Check only on	**	10.0
ing Phys After this funeral di	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig	28a. Date of Injur (Month, Day	y 28b. Time o	28c. In	4 Nursing no	ome 5 Reside 28d. Describe ho	ence 6/DiOther (Specify)
after death. Director: A in by the fu	Certification;	2 Accident Investigation 3 Suicide 6 Could not determine	ot be One Olean of Init	ury - At home, farm, st c. (Specify)			28f. Location (St City or Town	treet and Number on, State)	or Rural Route Number,
within 24 hours after de To the Funerel Direct completely filled in by the	edical C	29a. Certifier (Check only one) 29a. Certifying 2 Medical E	rnysician: To the best of xaminer: On the basis of and manner sta	examination and/or in	in occurred at the evestigation, in m	ume, date and place, y opinion, death occur	and due to the carred at the time, di	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	2 ^		29c. Lice	ense number	2	9d. Date signed (M	fonth, Day, Year)
		Alle	'ell			15830	5 /	thm (2	2001
3		30. Name and address of person w	no completed cause of de	eath (Item 23a) (Type	Prigt)	s Ba	Muc	e mo	4204
St Regist	ate	31 Date filed (Month, Day, Year)	2005 32 Registra	ar's Signature	ade				,

	Baltimore, Ma	
OSTrick, Arthur all los 2:33 Am.	Division of Vital Records, P.O. Box 68760,	the Hoomist or Attendition Developer. The leavest of the death of different he areas and

			For State Registrar		State o	of Maryl		artment <i>rtificate</i>			Mental Hy	gien Reg. N	201	05	12724
	Physici /Medio		1. Decedent's Name (Firs Arthur J								2. Date of De Month April		ay 2	rear 005	3. Time of Death 2:33 A.M.
1	Examir		4a. Facility Name (If not in Suburban	_		mber)		4b. City, To Bethe		ocation of Death			c. County of Montge		У
	Funeral Director		5. Social Security Number 578-46-4267	r 6. Se		7. Age (In) 82	vrs. last birthday Yrs.			f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 18	th y, Year	922	9. Birthp Coun I OW a	
	land ow		Usual Residence of Dece 10a. State 10b.	County		10c.	City, Town or L	ocation						1	0d. Inside City Limits
	e Man Ba-f sh	Director		ntgome	ry		Bethesd								1 □Yes 2X No
	h with th		10e. Street and Number 9722 Corkra:	n Lane				10f. Zip 0				-	itizen of Wh		*
336	s within 72 hours atter death with the Maryland Jiene. r then "natural", or items 23a or 28a-1 show Ite Medical Exa plicer must be motified at	by Funerai	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Dec Armed Fo 1 X Yes If Yes, Gi Year or D	edent Ever i orces? Ko 2 No ve WWII oates:	orca	Was Decede tf Yes, specif	y Cuban,	anic Origin? (Sp Mexican, Puerto Specify:	Decify Yes or No Decify Yes or No Decify Yes	-	14. Race Btack, Specify:	White,	etc.
21215-0036	"natura	Completed		Decedent's Edi ly highest grad			(Givi	edent's Usuat e kind of work DO NOT use	done du	on ring most of wor	orking 16b. Kind of Business/Industr			dustry	
212	d within giene.	Somp	Elementary/Secondary	(0-12)	College (1-4or 5+)	1	ninist:		r		U.	S. Pu	blic	Health
and	ould be filed Mental Hygie arked other atic evant, III	Be	17. Father's Name (First, Herman Aug		Ostdia	-k				8. Mother's Nam Ida U1m	ne (First, Middle,	Maide	n Sumame)		
Maryland	₹ D E E	2	19a. Informant's Name/R Charlotte	lelationship (T	ype, Print)		19b. Mail 972	ing Address (Street and	d Number or Ru	nber or Rural Route Number, City or Town, State, Zip Code) ne, Bethesda, Maryland 20817				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crer 1 □ Donation 5 ☐ C	mation 3 🗆		I		matory or oth Heaven	er place) LCemet	eryApril	Date 15, 2005 S	Silve		ng, Ma	aryland
Balti	permit. Departn Imports any inju		21. Signatule of Foneral	Service Licens	- Ra	М	01356 Be	2. Name and thesda thesda	Address a-Che	of Facility Rob vy Chas ry1and	ert A. e, Inc. 20814-35	Pum 75 501	phrey 557 Wi	Fun	eral Home nsin Ave.
23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each tine. Immediate Cause (Final disease or condition a										such as cardiac	or respiratory a	rrest,		0	Approximate Interval Between Onset and Death one day
	/Medical Examiner	L	resulting in death) Sequentially list condition	ns,	Due to	orasa con ite My	sequence of): ocardia			on				0	ne day
68760,	ficate be executed physicien and s the burial-transit	ai Examiner											one day		
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Q	w requires that the been signed by th should be detache	by	Part II. Other significant	conditions co	ntributing to d	eath but not	resulting in the	underlying cau	ısə givən	in Part I.					e cause of death? ably 4 XIUnknown
Vital Records,	The law ate has b page 2 si	Completed									24a. Was autop perfo 1 Yes	sy rmed?	pride	ere autop or to con ath? Yes	psy findings available inpletion of cause of
Vita	Physiclan: Th this certificate ral director, pag	o Be (25. Was case referred to examiner? 1 ☐ Yes 2 ☒ No	-	Hospital:	Inpatient 2			Othor		th (Check only o		- 7-		
on of	ng fter ine	-	27. Manner of Death	Pending investigation		of Injury of, Day Yea	2 ER/Outpatie 28b. Time of thickery		c. Injury a Work?	4 Nursing H	ome 5 Residence 1)
Division	al or Attai s after des al Diractor ed in by the	Certification:		Could not be determined	28e. Płace build	of Injury - A ing, etc. (Sp	At home, farm, st ecify)	reet, factory,	office		28f. Location (S City or Tov	Street a vn, Stat	nd Number 'e)	or Rurai	l Route Number,
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical	29a. Certifier 1 💢 C	Certifying Phy dedicat Exam	iner: On the b	e best of my easis of exam ner stated.	knowledge, dea nination and/or ir	th occurred at	the time, n my opin	date and place, ion, death occur	and due to the red at the time,	cause(s	s) and mann id place, and	er as sta d due to	ated. the cause(s)
)		W	29b. Signature and title of	dow	J MI			2	360				il 11		
	10+1		30. Name and address of Mohsin Ijaz						ckvil	lle, Mar	yland 2	085	2-3143	3	
	Sta Registr	_	31. Dete filed (Month, Day	y, Year) R 1 4 2	005	gistrar's Si	gnature	book		····					

	1	State of Maryland / Department of He State Registrar Certificate of D	ealth and M Death		giene) (005	12725
Physicia		I. Decedent's Name <i>(First, Middle, Last)</i> Ruth E. Pollard		2. Date of De	ath Day	Year	3. Time of Death
/Medica Examine	r 4	Star Facility Name (If not institution, give street and number) 4b. City, Town, or I Bulling	Location of Death	S Date of Bir		inty of Death	place (State or Foreign
Funeral Director		220-30-1218 1 M 20 F 81 Yrs. Months Days	Hours Min.	8. Date of Bir (Month, Da	Y-1923	Cour	Virginia
Maryland f show		Joan State 10b. County 10c. City, Town or Location MD Baltimore n/a				1	10d. Inside City Limits 1 ☐ Yes 2 No
th the Por 28a-	Funeral Director	10e. Street and Number 10f. Zip Code			10g. Citizen	of What Cour	ntry?
s 23a	al L	7308 Johnnycake Road 21228		ecify Yes or No	USA 14. F	Race - Americ	can Indian.
1213-UU30 within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show than "natural" or items 23a or 28a-f show	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of His If Yes, specify Cuban 1 Yes 2 No	Specify:	Rican, etc.)		Black, White, ecify: Black	etc.
Maryland 21215-UU36 nd 2 should be filed within 72 hours at alth and Mental Hygiene. 27 is marked other than "natural, or r traumatic event, the Medical Expra	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th 16a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired) Domestic	tion uring most of work	ing		f Business/In emaker	dustry
and Z d be filed v ntal Hygie ed othar t	Be		18. Mother's Nam	e (First, Middle E. Star-	, Maiden Sun		
Maryii id 2 shouk ith and Me ith and Me traumatic	0	19a. Informant's Name/Relationship (<i>Type, Print</i>) Marie Green/ Daughter 19b. Mailing Address (<i>Street</i> a. 8332 Western Wi					Code)
Baltimore, Maryland 21215-UU36 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place Crownsville Veterans	4-15		Crownsv		d .
Balti permit. Departm Importe any inju		21. Signature of Funeral Service Licenses 9200 Liberty					Faltimore Co.
Physician /Medical Examiner	er	288. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (ar as a consequence of): Due to (or a a consequence of):	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death Tws Bweeks Bweeks
	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or a la onsequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):					Bureks
o.O. Box of the death certification in the attending tached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 2 Setable 3 Ectopic pregnancy 3 Ectopic pregnancy 5 Other (specify) Setable 5 Other (spe			23d.	Date of deliv Month	Pery Day Year
rds, P. quires that n signed by	٥	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	1 _	tobacco use d		the cause of death?
	Completed			24a. Was auto perfo 1 Yes		4b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
f Vital F yelclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Dea	th <i>(Check only</i> ome 5 ☐ Res		Other (Speci	(6.)
On of ding Phyen. After this funeral di	on: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury		28d. Describe			.,,
isi itten deat deat deat tor:	Certification:		Yes 2 □No		(Street and Ni wn, State)	umber or Rur	ral Route Number,
Div To the Hospital or A within 24 hours after To the Funaral Dirac completely filled in b)	edicai Ce	29a. Certifier (Check only one)	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) and , date and pla	d manner as s ce, and due t	stated. to the cause(s)
To the within To the complex	Me	29b. Signature and title of certifier Stacy M Styphynson P100	A		: 1	gned (Month,	Day, Year) April 10200
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stacy Stephenson 900 Caton Ave Balti	mare Mi	D 212	29		
Sta Registr	1	31. Date filed (Month, Day, Year) APR 1 4 2005 32. Registrar's Signature					

	Physicia		1. Decedent's Name (First, Middle, La	Helen F	Ruth P	arker					2. Date of Dea	Day	Yeer 2005	3. Timerof Death	
	/Medic Examin		4a. Fecility Name (If not institution, gi	e street and numbe	or)		4b. City,	Town, or	Location of				nty of Death		
				Maris at Mer			1611-1-				nore City			ore City	
	Funeral			Sex 1 □ M 2 □ F 7. A	Age (In yrs. li 89	.,	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Yeer)	9. Birthp Coun	lace (State or Foreign stry)	
	Director		214-01-1048 Usual Residence of Decedent	/ \	08	· · · · · · · · · · · · · · · · · · ·					October 9	9, 1915		Maryland	
14	nylanc how		10a. State 10b. County		10c. City	, Town or Lo	ocation						1	0d. Inside City Limit	
SI	ith the Marylan or 28a-1 show	Director	Trical Floring	loward					licott Ci	ity				1 □ Yes 2 No	
w	with the	Dire	10e. Street and Number				10f. Zip	Code	210	043		10g. Citizen	of What Coun U.S.	,	
	leath	Funeral	4932 Avoca Ave	12. Was Deceder	nt Ever in U.	S. 13.	Was Deced	le/nt of Hi			ecify Yes or No- Rican, etc.)	14. F	Race - Americ		
9	or Iter	Fun	1 Never Married 2 Married	Armed Force	S? No			ify Cuba	n, Mexicar Specify:		Rican, etc.)		Black, White,	white, etc. White	
5-0036	iours iral',	d by	3 Widowed 4 Divorced	Year or Dates	s:			//			Specify:				
15-("natu	Completed	15. Decedent's E (Specify only highest g	ade completed)		16a. Dece (Give life.	dent's Usua kind of woi DO NOT us	al Occupa rk done d se retired	ation <i>furing m</i> os ')	t of work	ring	16b. Kind o	b. Kind of Business/Industry Medical Record		
2121	withii iene. r than	dmo	Elementary/Secondary (0-12)	College (1-4o	or 5+)				Clerk				Medical	1100010	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It a Medical Examination at the multiple at once.	Be C	17. Father's Name (First, Middle, Las	t)					18. Mothe	er's Nam	e (First, Middle,	Maiden Suп	name)		
ylar	Menta Menta Brked	To E	Royal D	onald Parker							Heler	Angela McFee			
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number Mrs. Ann. Lowe Neice 4932 Avoca Ave Ellicott City, Maryland									wn, State, Zip	Code)		
	1 and Health em 27 ther tr		Mrs. Ann Lowe 20a. Method of Disposition	Ne	20b. P	ace of Dispo	sition (Nan	ne of	1	19-50	ıy, iviai yları Date		on - City or To	wn, State	
Baltimore,	Pages nent of H int: If its		1 Surial 2 Cremation 3 4 Donation 5 Other (Spec		te	emetery, crei	-	•	1	03	/28/2005		Ť	e, Maryland	
葦	permit. P Departme Importan any injur:		21. Signature of Funeral Service Lice	4	NA KOLZ	rest Law	n Mem 2. Name an			5				,	
B	permi Depar Impor any ir		► Weldutto	hertri	ent.		9	Slack F	Funeral	Home	e, P.A. Pike Ellicot	t City M	D.21043		
8760,	/Medical Examiner physician and physician and the prinal-transit the prinal-transit physician and the prinal-transit physician and physician and physician are provided the prinal-transit physician and physician are provided the physician and physician are provided the physician are provided	dicai Examiner	d												
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med										23d. Date of delivery Month Day Year			
	ss that gned b	by P	Part II. Other significant conditions	contributing to death	but opt resu	ulting in the u	inderlying c	ause give	en in Part I	l.				ne cause of death?	
ord	requir een si nould l		- Quest	uve local	Jack	W					1 L Y	es 2□No			
Division of Vital Records,	n: The law icate has b r, page 2 sl	Completed	- My flute	nswu	V							med? 2☐No	b. Were auto prior to cor death? 1 \sum Yes	psy findings available inpletion of cause of	
Z.	siciar s certif lirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	atient 2 🗆	ER/Outpatie	nt 3 🗆 DC	Othe	25	e of Deat ursing Ho	th (Check only o	KEYE	Sther (Specific	v)	
of	g Phy er this eral d		27. Manner of Death	28a. Date of la (Month, I		28b. Time o		28c. Injun	/ at	aromy ric	28d. Describe h	ow inj	-		
ion	ath. or: Aft	atio	1 ☐ Accident 5 ☐ Pending investigati	on	Day roary	injury	М		Yes 2	No					
ξį	or Atter de directe	Certification;	3 ☐ Suicide 6 ☐ Could not determine	a 280. Piace of	Injury - At ho etc. (Specify	me, farm, st	reet, factory	y, office			28f. Location (S City or Tow	itreet and Nu n, State)	imber or Rura	l Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Ce	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examina	wledge, deat tion and/or ir	h occurred evestigation	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the cred at the time, o	cause(s) and date and plac	manner as st	tated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	00			290		e number	_			ned (Month,		
) 11 9/10CA	elle	er 1	W		0	07	931	0	Mar	ch 28	2005	
-			30. Name and artifess of person wh	6	eld	123a) (Type,	Print)	1 51	- Po.	11	Pace	Bolo	t., me	8,2005 d 2/202	
	Sta Regist		31. Date filed (Month, Day, Year) APR 1	69	trar's Signa	ture	book	U					,		
	negist	(e)	APK I	# 4000	CHURCH STATE	1									

1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2GINIA 1504 APRIL 2005 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SMINT AGNES HEALTH CARE BACTIMORF 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 F 213-96-3130 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumetic avant. The Medical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 Who If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tam 27 is markad ott IRGINIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If itam 27 is y or other trai TIMOREMD. 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State BAYNEW CREMATORY permit. Page Department of Important: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena MD. 21122 Part1. Enter the disease of cod, pleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part1 Enter the disease Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** Immediate Cause (F disease or condition resulting in death) PULMONARY HYPERTENSION IXEAR /Medical Due to (or as a consequence of): **Examiner** ADVANCED HUMAN IMMUNOPEFICIENCY 10 YEARS Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death for in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, page 2 should be 1 □ Yes 2 □ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 3 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) P17608 . 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. JACKSON 900, CATON. AVENUE BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DEBORAH Baltimore, Maryland 21215-0036 Dowell, Division of Vital Records, P.O. Box 68760,

Pleas		k Indelible Ink. Ensure Department of Health and	-	-	
1 _ State	State of Maryland / 1	Certificate of Death	-	11115	12728
Registrar 1. Decedent's Name (First, Middle	(lact)	Certificate of Death	Reg. I	40.	3. Time of Death
			Month E	Day Year	- 11 - 12 M
DEBURAH E.	POWEIL			7 2005	
4a. Facility Name (If not institution		4b. City, Town, or Location of Dea	ath	4c. County of Dear	th
MERCY HUSP		DAI FIMILE		Ma	
5. Social Security Number 220 80 1419	6. Sex 1 □ M 2 □ F 7. Age (In yrs. last bit	Yrs. If Under 1 Year If Under 24 Hr Months Days Hours Min		C	hplace (State or Foreign untry)
Usual Residence of Decedent					
10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
M.D M	la Barto	MURE			1 Nes 2 No
10e. Street and Number		10f. Zip Code	10g. (Citizen of What Co	ountry?
609 Clinton	v 54	21205	U	5.12,	
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	14. Race - Ame Black, Whit	nican Indian,
1 Never Married 2 Marri	ed 1 Tyes 2 No	1 ☐ Yes 2 ☐ No Specify:	, , , , , , , , , , , , , , , , , , , ,		
3 Widowed 4 Divorced	Year or Dates:	TE 163 ZESHO Specify.		Specify: 3/6	ICIC
15. Decedent (Specify only highes	's Education 16a	Decedent's Usual Occupation (Give kind of work done during most of w	orkina 16b.	Kind of Business/	Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)			
12		JULISE REEPING	140	MERREPER	
17. Father's Name (First, Middle, I	Last)	18. Mother's Na	ame (First, Middle, Maide	en Sumame)	
UNKNOWN		DAthe	INE POWELL		
19a, Informant's Name/Relationsh	nip (Type, Print) 195	. Mailing Address (Street and Number or F		or Town, State, 2	Zip Code)
NOShERINE MC	Collarge 60	9 Clinton St Bart	mine NO 2/2	205	
20a. Method of Disposition	20b. Place o	f Disposition (Name of		Location - City or	Town, State
1 Burial 2 Cremation	3 Removal from State	ry, crematory or other place)			
`4 □ Donation 5 □ Other (Sp	Decity) CREENA	22. Name and Addr ss of Facility	2/05 2	altimore 1	40
21. Signature of Funeral Service L	Licensee	22. Name and Address of Facility	BEHS Fune	ral Home	
Sostucio L	Sell	1129 N. Caroline	# Briltim	ME MD 21	213
23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused the death. Do	not enter the mode of dying, such as cardia	ac or respiratory arrest,		Approximate
Immediate Cause (Final	billy one cause on each line.	east conc			Interval Between Onset and Death
disease or condition resulting in death)	a		0		
	Due to (or as a consequence	or):			
Sequentially list conditions,	b				
lary leading to immediate cause. Enter Underlying Cause (Disease or injury	Dire to (or as a cunsequence)	ory.			
that initiated events resulting in death) Last	с				
resuming in death) Last	Due to (or as a consequence	of):			
	d				
				224	
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deli	verv
in the past 12 months?	1 Live birth 2 Fetal death	3 Ectopic pregnancy		Month	Day Year

Physician /Medical Examiner Medical Certification; To Be Completed by Physician/Medical Examiner

attending physician and for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

9 Unknown

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or tlems 23a or 28a-f show any injury or other traumatic event. If a Medical Event at must be notified at once.

Be Completed by Funeral Director

၉

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2

24a.	Was an	24b.	Were autopsy fir	ndinos availat
	1 🗆 Yes	2 No	3 Probably	4 Unknow
238.	DIG (00ac)	co use con	tribute to the cau	ise of death?

autopsy performed? Yes 26. Place of Death (Check only one)

prior to completion of cause of death?

1 Yes 2 No

25. Was case referre examiner?	d to medical
1 ☐ Yes 2 ☑ Ñ	o
27. Manner of Death	

1 Natural

2 Accident

3 🗍 Suicide

4 Homicide

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospital:

ER/Outpatient	3 🗍	DOA	Carer:	4 🗌 Nursi
28b. Time of Injury		28c.	Injury at Work?	
	M	1	1 Yes	s 2 \square No

☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)	2 Medical Exam	iner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
29b. Signature and	title of certifier	\	29c. License number	29d. Date signed (Month, Day, Year)

6 Could not be determined

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

31. Date filed (Month, Day, Year) 4 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** lie El-izabeth Rites 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NIA Baltimore STella Marris Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔭 F Months 214-50-6568 Yrs. Director 56 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits treumetic event, the Medical Examiner must be notified at Director NA 1XYes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e or U.S.A. 1101 uantril WAY 21213 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ð Specify: 3 ☐ Widowed 4 Divorced White "neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than any injury or other treumetic event, tha Me JERS. Elementary/Secondary (0-12) College (1-4or 5+) Clerical Clerical 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Lee Banner aura V09-2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Banner 530 Arama Drive Failston MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Apr. 16,05 Catensville. Metro Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grayson Funesal Home North ave. Balto. md Ronald a a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Cuncer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Cau Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by 1☑Yes 2□No 3□Probably 4□Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2 No of Vital 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Division s after dea. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel C
completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18/2005 1740854 30. Name and address of person who complete vause of death (Item 23a) (Type, Print) RISPBERG DUI 32. Registrar's Signature PI Baltimore DaviD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State o	f Maryland		artment of H		nd Mental i	Hygier Reg. 1	ZUUD	12730
			1. Decedent's Name (First, Middle	e, Last)					2. Date o	f Death		3. Time of Death
	Physici /Medic		Joan Pa	atricia	Ruscit	to			Apri		Day Year 3, 2005	3:30 A ^M
	Examir		4a, Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or	Location of	Death		4c. County of Dea	
			Future Care Che	esapeake			Arno1				Anne Ar	unde1
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. la:		If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date o	Birth Day, Yea	9. Bi	rthplace (State or Foreign ountry)
Ļ	Director		577-36-6571	ILIWI ZUAF	74	Yrs.			Sept	8, 19	930 Was	hington, DC
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary	ō	Maryland Anne A	Arunde1		Ca	mbrills					1 □ Yes 2 € No
	28a	Directo	10e. Street and Number	Tunder		Ga	10f, Zip Code			10a.	Citizen of What C	
	3e of		2243 Dairy Farm	n Road				054			nited St	*
	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "neturel", or Items 23e or 28e-f show event, the Madreal Examinar must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S.	. 13. V	Vas Decedent of His Yes, specify Cubar		in? (Specify Yes o	No-	14. Race - Am	erican Indian,
9	after or Ite		1 ☐ Never Married 2X Marr	ied 1 ☐ Yes	2 🕅 No				Puerto Rican, etc.)	Black, Whi	te, etc.
8	rel',	d by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve ates:		☐ Yes 2X No	Specify:			Specify:	White
21215-0036	72 h	Completed	15. Decedent (Specify only highes			16a. Deced	ent's Usual Occupa	tion urina most	of workin a	16b.	Kind of Business	/Industry
2	vithin ne. hen.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d OO NOT use retired)				. 1	
	filed v Hygie other ti		12th 17. Father's Name (First, Middle,	(ant)		Offi	ce work/S				Unknown	
ä	e d la be	Be		,	Clark				's Name <i>(First, Mid</i> 1ary	_{idle, Maid} Ochs	en Sumame)	
Maryland	2 should be and Mental is marked c	70	19a. Informant's Name/Relations		JIAIK	10b Mailin	g Address (Street a					7'. 0. 4.1
<u>8</u>	s 1 and 2 should f Health and Mer item 27 Is marke other treumetic				. ,		,					,
ā,	s 1 and 3 f Health item 27 other tr		Ronald M. Rhine 20a. Method of Disposition	enardt, Si	20b. Pla	ce of Dispos	Dairy Far		ad Gambr Date		Mary La	
٥	Pages nent of int: If it		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)				natory or other place leaven Cen		/15./2005		ilver Sp	
Baltimore,	그 문문경	H	21. Signature of Funeral Service		Joace	22	Name and Address	s of Facility		-		
ä	Depa Impo eny ir	, lä	Kluste B	thomas	M00957	D	onaldson 411 Annap	Funer	al Home	cre	matory,	P.A.
			23a. Part LEnter the disease, or shock or heart failure. List	complications that of			er the mode of dying	, such as c	ardiac or respirato	y arrest,	, Maryra	Approximate
	Pnysician i		Immediate Cause (Final	Bre	1							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	or as a conseque	ince of):						
	Examiner		Sequentially list conditions	h	metas	カナ	c to 1	i've,				months
	p #	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseque	nou uth						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
Š,	cate be executed physician and the burial-transit	Ē	resulting in death) Last	Due to	(or as a conseque	nce of):						
8/60,	cate b	dical		d								
٥ ×		/Me	IF FEMALE:	220 16 1100 011					-			
X Q Q	death of attended for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnance inth 2 Fetal de	eath 3	Ectopic pregnancy				23d. Date of de Month	livery Day Year
o.	that the death certificed by the attending detached for use as	Physiclan/Me	1 □ Yes 2 No 9 □ Unknown	9□ Unkn	ant at time of dear own	tn 5⊔	Other (specify)			_		,
Ž.	requires that the		Part . Other significant condition	ns contributing to de	ath but not resulti	ing in the un	derlying cause give	n in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
g	w requires that been signed be should be det	d by	Anasarca	bilas	eval	ple	rival		1	□Yes	2 X No 3 □ Pi	robably 4 Unknown
cora	> 0 0	lete	efficions	Huge	alhi	LI MOI	n Quià		24a. V	fac on	24h Wasa ai	utopsy findings available
Ĕ	The law cate has b page 2 st	Completed	10 ft 0.	110	- 1- 1	0 70 17	MONIO		a	utopsy erformed)	prior to death?	completion of cause of
VII	icien: Th certificate rector, pag	Ö	25. Was case referred to medical	Mary	a D C	255		00 Dinne	1 □ Ye		lo 1 ☐ Yes	2 □ No
	Physicien: this certific ral director,	0 8	examiner?	Hospital:	npatient 2□EF	R/Outpatient	Otho		of Death (Check or sing Home 5 - R		6 DOther (Cre	aifu)
0	ding Phys h. After this funeral dir	L I	27. Manner of Leath	28a. Date	of Injury 2	8b. Time of	28c. Injury	at			ury occurred	City)
Ston	Attending or death. sector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investig	9	h, Day Year)	Injury	Work′ M 1 □ Y	? es 2 □ N	0			
<u> </u>	or Atten after deatl Director: in by the	Certification	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Place	of Injury - At hom- ng, etc. (Specify)	θ, farm, stre	et, factory, office		28f. Locatio	n (Street a	and Number or Ru	ural Route Number,
5	itel or A rs after el Direc led in by	Cer		buildi	ng, etc. (opeany)				Chy or	10W11, 3ta	110)	
	tospi t hou uner	edical	29a. Certifier Certifyin	g Physicien: To the Exeminer: On the ba	best of my knowle	edge, death	occurred at the time	e, date and	place, and due to	he cause	s) and manner as	s stated.
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medi	Une)	and mani	ner stated.							
	5 T K		29b. Signature and title of certifier	n	150	~	29c. License	number) UII	200	29d. D	ate signed (Mont	n, Day, Year)
O	1		20 80	the car star t				119	177		7.12.	OJ
h	-		30. Dame and address of person	- Completed caus	e of death (Item 2	3a) (Type, F	terans	the.	hintou	OYN	1100m	willo up
	Sta	e	3L Date filed (Month, Day, Year)	32.	egistrar's Signatu		LIVIS	117	10000		است	2114.0
	Registra		APR 1	4 2005	egistrar's Signatu	1. 14	MASC.		•			2110.0

			State of Maryland / Department of Health and M Certificate of Death		iene _{eg. No.} 2005	12731	
	Physician	n	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death	
1	/Medica	al -	Dorothy G. Sweeten 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	April I	4c. County of Death	10:50 PM	
1	Examine	er	Asbury-Solomons Island Health Care Center Solomons		Calvert	'	
	Funeral Director		5. Social Security Number 219-10-1998 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday) 1 □ Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min	8. Date of Birth (Month, Day, May 28,	Year) 9. Birth Co. 1923 Mar	nplace (State or Foreign unity) 'Yland	
	and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	Maryl First	إة	MD Calvert Solomons			1 □ Yes 2 □ No	
	or 28s	8	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	untry?	
	ath w	ig i	409 Epworth Court Box 522 20688	aif. Was as Na	USA 14. Race - Amer	iona Indian	
020	urs after da Ni, or item Examiner r	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Merried 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Specify: 1 □ Yes 2 ☒ No Specify:	city fes of No- Rican, etc.)	Black, White	e, etc.	
Baltimore, Maryland 21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mantal Hygiane. Item 27 is marked other than "natural", or Hems 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Secretary	ng	16b. Kind of Business/I	ndustry unk	
d 2	Hygid other	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, I	Maiden Sumame)	-	
ylar	2 should be filed with and Mantal Hygiane. Is marked other thar aumatic event, the	0		e Norris			
Mar	l 2 sho l and l ls me raume		19a. Informant's Name/Relationship (Type, Print) Donald Sweeten/spouse 19b. Mailing Address (Street and Number or Rura 409 Epworth Court Box				
e,	s 1 and 2 of Health Item 27 I	-	Donald Sweeten/spouse 409 Epworth Court Box 20a. Method of Disposition 20b. Place of Disposition (Name of cemelery, cremetory or other place)		OMONS, MD 2		
<u>m</u>	8 ° = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)				
Balt	permit. Pag Department Important: Il any Injury o		21. Signature of Euneral Service Licensee Ponald S. Wade, Director State Anatomy Board Baltimore, MD 21201	655 W.	Baltimore	Street	
	Pr.		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arre	est,	Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. ESOPA Sea/ CANC Due to (or as a consequence of):	ER	† † ** ** **	Onset and Death	
Box 68760,	ificata ba physicia as the bur	edicai	9	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b			
_	daath e atta	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld to	bacco use contribute	to the cause of death?	
P.O.	as that tha da igned by the a be detached		Digbetes	1)XX	es 2 No 3 Pr	obably 4 ☐ Unknown	
of Vital Records,	The law raquiras that tha daath cert ate has been signed by the attanding page 2 should be detached for use.	Completed by	COPD	24a. Was a perform	med?	Vere autopsy findings ivailable prior to completion of cause of death?	
- R	The la	E		1 🗆 Ye	60 2 XVc 1	☐Yes 2☐No	
Vita	entific ector	ñ	25. Was case referred to medical examiner? Hospital: Other:				
on of	ng Physical discrete	tion: To	27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Menner of Death 28c. Injury at 1 Yes 2 No. 2		ence 6 □Other (Spec ow injury occurred	ify)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After complataly filled in by the fune	Certification:	2 Action 0 Could not be	28f. Location (St City or Town	treet and Number or Ru n, State)	ra i Route Number,	
	Hospital	Medical C	29a. Certifier (Check only one) Check only one)				
	To the To the Complain	M	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Monti	n, Day, Year)	
			1 (Joseph / Swyn m) 1) 0052	142	April	8,2005	
			30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Barth 110 Hospital Dr. Prince Fred	sick	mi		
	State	e	31. Date filed (World), Day, Teel)		7		
	Registra	r	APR 1 4 2005 Been de Marie				

VIN	SQUIRE	ELI	For Stata	State of Ma	ryland / Dep	artment of F				5 1270	20
			Registrar 1. Decedent's Name (First, Middle, L	ast)		timeate of t	Death	2. Date of Dea	Reg. No. 👇 💛 🔾 🥫	3. Time of Deat	<u>) /</u>
	Physic		CALVIN		50	DUIRRE	1 111	APRIL	11, 2005		
	/Medi Examii		4a. Facility Name (If not institution, ga	ive street and number)			Location of Deal		4c. County of De		—
			UNIVERSITY HOSPIT	[AL		BALTIMOR	RE CITY		i	1/A	
	Funeral		5. Social Security Number 6.	Sex 7. Age 12 M 2 F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(Year) 9. B	rthplace (State or Fore	eign
	Director		Usual Residence of Decedent	TAQ W Z L	S Yrs.			FEB. 06		PARYLAN	10
	land		10a. State 10b. County		10c. City, Town or Lo	ocation			•	10d. Inside City Lim	nits
	the Marylar 28a-f show	to	MARWAND	VIA		BAI	TIMO	RE O	171	1 🖫 Yes 2 🗆	
	ith the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?	
	23a c	Funeral Director	4101 MCD	OWELL L	ANE		2122	7	45	A.	
	itams	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh		
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give)	1 ☐ Yes 2 🖾 No	Specify:		Specify: //	1 :	
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-f show ther the Medical Exam her mall be inclifted at		15. Decedent's 8	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Busines	Maduata	
215	nin 72	Completed	(Specify only highest g. Elementary/Secondary (0-12)	rade completed) College (1-4or 5+	(Give	kind of work done of DO NOT use retired	during most of wo	rking	TOD. TAILE OF DUSTINGS.	windustry	
2121	filed witl Hygiene other the	E O	10 HGRADE	College (1-40) 3+	CA	SHIER	2/C00	K	RESTA	URANT	-
p	oe file tal Hy d oth	Be (17. Father's Name (First, Middle, Las			~	18. Mother's Na	me (First, Middle,	Maiden Sumame)		
Уa	2 should be and Mental is marked o	မှ	CALVIN	SQUII	RREL	JK.	CAT	HY	SM	ITH	
Maryland	ges 1 and 2 should be filed within 72 hr t of Heelth and Mental Hyglene. If item 27 is marked other than "natur or other traumatic event, the Mudical	1 8	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a	and Number or Ri	ural Réute Numbe	r, City or Town, State.	Zip Code)	_
	1 and Heeltl am 2 ther 1	1 3	20a. Method of Disposition	(MOTHE	20b. Place of Dispo	/ MC_DO	WELL	ANEX	DALTO, M	D. 2122	1
ğ	ages nt of I t: if its		1 ⊠Burial 2 ☐ Cremation 3		cemetery, crei	natory or other plac	' 1	Jaio /	20c. Location - City o		
3altimore,	permit. Pag Department important: any injury o		4 □ Donation 5 □ Other (Spec21. Signature of Funeral Service Lice	**		EM. PA		16-05	WOODLA	WN HARYL	AND
Ba	permit. Departn imports any inju		Dotah	N/1)Ille	ims !	TO, SEP	H H	SROQUA	OR FUN	ERAL HOI	ME
	Inysician /Medical Examiner	ner	23a. Pan1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Journal of Cause (Disease or injury)	a. Due to (or as a	consequence of):	wome				Approximate Interval Batween Onset and Death	
8760, <	ate be executed hysician and the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						
687	ficate physics the	73	====	d							-
P.O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year	
0_	that the need by detac	y P	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	pacco use contribute t	o the cause of death?	
rds	equires sen sign ould be							1 🗆 Y	es 2 / 0, No 3□P	robably 4 Unknov	wn
Division of Vital Records,	aw requ s been 2 shout	Completed						24a. Was a		utopsy findings availat	ble
Ä	The lay ate has page 2	E			·			autops perform	ned? death?	completion of cause o s 2 □ No	jf
ita	ician: certifica rector, p	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th Check on on		2 110	-
>	S 5	유	1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient	2 XER/Outpatien	t 3 DOA Othe	er: 4 Nursing H	lome 5 🗆 Reside	ence 6 Other (Spe	ecify)	
U C		on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	w injury occurred		
<u>S</u>	Attanding r death. actor: After by the fune	Certification:	2 Accident investigated	2	82:00		∕es 2∭XNo	Subject	t was s		
Ν	or Al after of Dirac in by	artif	4 Homicide determined		/ - At home, farm, str (Specify) くナノシ			City or Towr	reet and Number or R n. State) 1826 w	ural Route Number, 125 Wood Av	12
	pours ours merai filled		29a. Certifier 1 ☐ Certifying P	hysician: To the best of			ne date and place	Baltime			
	To the Hospital or Attan within 24 hours after deatl To tha Funeral Diractor: completely filled in by the	edical	(Check only 2X Medical Exa	miner: On the basis of e	xamination and/or in	estigation, in my op	pinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)	
	To th within To th compi	Me	29b. Signature and title of certifier	~		29c. License	number	2	9d. Date signed (Mon		
			I hay his	, m.D		OC	ME		APRIL 12	2, 2005	
-	2		30. Name and address of person who	~	th (Item 23a) (Type,		enn Stre	et Balt	imore, Mar	yland 2120)1
	Sta	te	31. Date filod (Month, Day, Year)	32. Pegistrar	s Signature						
	Registr	ar	APR 1 4 2	005	. K. A.	and)					

			State of Maryland / Department of Health and Mental Hygiene 0 5 1 2 7 3 3
4			1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici /Medi	al	LOLA VIRGINIA SMITH April 09, 2005 1:10 PM
100	Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Toym, or Location of Death 4c. County of Death City Ac. County of Death Ac. County of Death
- 1	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (Th yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23s or 28a-f show other treumetic event, the Marical Exc. interf. 431 be retified at	Director	MARYLAND NIA BALTIMORE CITY DYES 2 NO
	h with	al Dir	10e. Street and Number 10f. Zip Code 10f. Zip Code 10g. Citizen of What Country?
	ter deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
980	urs afte		1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: Specify
2-0	72 hor	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (UNEM PLOYED) (Give kind of work done during most of working
21215-0036	filed within Hygiene. other than '	Completed by	Elamentary/Secondary (0·12) College (1-4or 5+)
	be filed ital Hygie of other event, the	Be C	17. Father's Name (First, Middle, Last) (UNKNOWN) 18. Mother's Name (First, Middle, Maiden Surname)
Maryland	should be ind Mental s marked o umetic eve	2	MARY HENRY AYERS
	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City of Town, State, Zip Code) ERNEST W Smith (50N) 1026 BENNETT PLACE BALTO, 146. 21223
Baltimore,	0 = =		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
tim	Pa		"4 Donation 5 Other (Specify) METRO CREMATORY 04-15-05 BALTIMORE MA
Ba	permit. Departn Importe any inju		*4 Donation 5 Other (Specify) METRO CREMATORY 14-15-05 BALTIMORE MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN TR. F-UNERAL HOME Johnson N. F-ULTON AVE. BALTO, HD. 21217
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
97	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death
	Examiner		Due to (or as a consequence of):
1/	p iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
V	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
8760,	cate be e physiciar the burit	dical E	d
9		Med	IF FEMALE:
Box	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Day Year
P.0	that the de led by the a detached	hys	9 Unknown 9U Unknown
Ś	es be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1
Record	law as b	ompleted	24a. Was an autopsy findings available prior to completion of cause of
E B	The ate h page	Com	autopsy prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
Vital	Physicien: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner? 1
n of		-	27. Manner of Death 1 Manual S Pending 28a. Date of Injury (Month, Day Year) 1 Manual S Pending 28b. Date of Injury at Work? 28c. Injury at Work?
Division	Attending or death. ector: After by the fune	ertification:	2 Accident investigation M 1 Yes 2 No
Di∨	itel or Attencirs after deathral Director:	0	4 Homicide determined building, etc. (Specify)
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	with To To	M	29b. Signature and title of certifier M.D. 29c. License number 29d. Date signed (Month, Day, Year) April 09, 2005
_	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AND GENERAL HOSpital
1	Sta Registr		31. Date filed (Month, Day, Year) APR 1 4 2005 32. Registrar's Signature
			There I was

pe or Print in Black Indelible Ink. Ens. All Copies Are Legible. Amend Item 23a State of Maryland / Departing the Alth and Mental Hygiene 1 - For All State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2005 /Medical 4c. County of Deeth Name (If not institution, give street and number) Jown, or Location of Death **Examiner** Social Security Number Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 □XM 2 □ F Director 216 68 5100 49 24, 1955 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? is marked other then "natural", or Items 23a or 28a-f shot treumatic event, tre Medical Exercities in mast be recified at 1 X Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 ELDERON AVE. 21215 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 XNo Yes, Give 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify à 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed with Hygiene. 2 YEARS SECURITY GUARD .1 and 2 should be filed with Health and Mental Hygien tam 27 is marked other th **AFRO** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OLLIE C. SAWYER SR. CATHERINE THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health DEBROAH SAWYER (WIFE) 4201 ELDERON AVE. BAITTMORE, MARYLAND 21215 othar Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages permit. Pages Department of Important: If it any injury or or 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL PARK APRIL 8, 2005 BALTIMORE, MARYLAND 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME Signature of Funeral Service License 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MACK SSIL Pneumonia Physician /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if a py backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Diabetes The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. should be 1 Yes 2 No 3 Probably 4 Mhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ₩ lo 24a. Was an page 2 Jas autopsy perform certificate 1 🗆 Yes 2 200 of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Phpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 WNo 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attanding Division 1 Accident 5 Pending investigation death. 2 No 1 Tes Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, ss of person with 2. Registrar's Signature State 1 4 2005 Registrar

			For State Registrar	State of M	larylan	_	artment of h		nd Mental H	ygien Reg. Ne	13 0 0	
			Decedent's Name (First, Middle	, Last)			timouto or	Dodin	2. Date of D	eath	to Wall	3. Time of Death
	Physici		Richard	Nelson	S	eaborg			Month April	11 ,		4:45 A M
	/Medic Examin		4a. Fecility Name (If not institution				4b. City, Town, o	or Location of			c. County of De	
			Carroll County	Hospital Co	enter		West	minste	r	(Carroll	
	Funeral Director		5. Social Security Number 322–22–6589	6. Sex 7. A 1 X M 2 □ F	ge (In yrs. 74	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of B (Month, L April	irth Day, Year 17 ,	1930 I	irthplace (State or Foreign Country) 11inois
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ecation					10d. Inside City Limits
	Manyi f sho	ō	Maryland Carro	1 1								1 ☐ Yes 2 No
	28a-	Funeral Director	Maryland Carro	LL		пашр	stead 10f. Zip Code			10g. C	itizen of What 0	Country?
	h with	0	3730 Grave Run	Road			Hamps	stead		T	JSA	
	deat	ner	11. Marital Status	12. Was Deceden Armed Forces		.S. 13.			in? (Specify Yes or N Puerto Rican, etc.)		14. Race - Am	
36	d within 72 hours after death with the Maryland Jene. r than "natural", or Itema 23a or 28a-f ehow The Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced]No		1 □ Yes 2∏ No		ruerto nican, etc.)		Black, Wh Specify:	
21215-0036	2 hou	ted	15. Decedent	's Education	1931-	16a. Dece	dent's Usual Occup	pation		16b. l	Kind of Busines	Whites/Industry
215	within 72 ene. than "na	ple	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or	5+)	(Give	kind of work done DO NOT use retire	during most (d)	of working	Mar	yland I	Department of
7	filed wit Hygiene ther the	Completed	12	04		Ad	ministra	tor			-	alth & Hygien
pu	be filed Ital Hygi of other event, I	Be	17. Father's Name (First, Middle, I					18. Mother	's Name (First, Midd	le, Maide	n Surname)	
₹	should nd Men marke umatic	2	Leonard		aborg			A1ma			Welson	
Maryland	C1 00 70 00		19a. Informant's Name/Relationsh				•		or Rural Route Num			
	is 1 and of Health item 27 other to		Phyllis M. Seabo	org/wire	20b. P		Grave Ri esition (Name of matory or other pla		d, Hampste	_	MD 210 ocation - City of	
р	0 = 0		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		9			1	4/14/05			
Baltimore,	# 된 뿐 글 .		21 Sonature Furjeral Service	114	рат	22	-Washingt	ss of Facility			irel, Ma	•
B	Depa Impo any ir		bryan W. Cla	Luce		L	emmon Fur O W. Pado	neral I	Home of Du bad, Timor	ılane	y Valle	y Inc.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the deat							Approximate Interval Between
	Pnysician	7	Immediate Cause (Final disease or condition		500	2'.2						Onset and Death
	/Medical		resulting in death)	Due to (or a	s a conseq	uence of):						10 443
	Examiner		Sequentially list conditions.	b	1etas	staho	Meso	Rel	roma			3 45
	ed sit	lae	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a conseq	uence of):						3
V	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consed	uence of):						
8760,	icate be executed physician and s the burial-transit	cal E			,							
687	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edlc		d.								
Вох	eath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7-				23d. Date of de	elivery
œ.	death	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth			Ectopic pregnanc Other <i>(specify)</i>	у		[Month	Day Year
P.O.	at the by th	hys	9 Unknown	9□ Unknown								
	res that the de signed by the a be detached f	by	Part II. Other significant condition		but not res	ulting in the u	nderlying cause gr	ven in Part I.				to the cause of death?
ord	w require been sig should b	ted	Amril ho	cilla hun,					- '-	Yes 2	- 1	Probably 4 Unknown
Records,	has b	Completed							24a. Wa	s an opsy formed?	24b. Were a prior to death?	autopsy findings available completion of cause of
alF	The sage								1 ☐ Yes	2 X N		
Vital	Physician: r this certificantal director,	Be c	25. Was case referred to medical examiner?	Hospital:		55/0	Ott	.00	of Death (Check only			
of	nding Phyeician: th. : After this certifica e funeral director,	.: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inj	ury	ER/Outpatier 28b. Time o	1 3 DON	4 🗀 14013	sing Home 5 Res			ecity)
lo	Attending r death. ector: After y the fune	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investig	g (Month, D	ay Year)	Injury		rk? ∣Yes 2⊟N	0			
Division of	Atternation of the part of the	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	286. Place of it	njury - At ho	ome, farm, str	eet, factory, office			(Street a		Rural Route Number,
Ö	tal or rs afte al Dire	Cert	Tomodo	building, e	ic. (opecii)	y)			Only of 1	Jim, Jiai	6)	h
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the bes Examiner: On the basis and manner s	of examina	wiedgé, deat tion and/or in	n occurred at the ti vestigation, in my o	me, date and opinion, death	place, and due to the occurred at the time	e cause(s e, date an	s) and manner and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1			29c. Licens				ate signed (Mor	
			Dahah	manos	26 6	20	HS	5393	9	4	1/11/09	
	9+1		30. Name and address of person Babak Imo	noel, Do	412	Malcol	m Dr. ;	Suik 3	304; We			MD 21157
	Sta Registr		31. Date filed (Month, Day, Year)	32. Resis	trar's Signa	iture	park			<u>_</u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Month 5:10 A. **Physician** Still Claudia Ann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham Doctors Hospital Lanham If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 ☐ M 2 ☑ F Yrs. 49 Director 218-68-3224 Aug. 10.1955 Marvland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Forestville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20747 1922 Rochele Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Building Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Custodian 11th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If item 27 is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Betty D. Hicks Cage Marshall ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1902 Rochele Avenue Apt 1728 Forestville, MD 20747 Cindy Still (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State Aprilate 6, 200 520c. Location - City or Town, State injury or Forestville, MD Epiphany Episcopal CHL Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Syndwas Pnysician HOURT /Medical Due to (or as a consequence of): Nocrosis of small bowel **Examiner** GAngvenow Sequentially list conditions, any, labor of conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Wee Kr Hospitel or Attending Physician: The law requires that the death certificate be executed Bowel Ischemic Due to (or as a consequence of) Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel E Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

State Registrar DHMH 17 Rev 1/2001

To the

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who complet

2005

eath (Item 23a) (Type, Print) WA

and manner stated.

E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Bowie

00052865

K. Michael Figaro, MD

29d. Date signed (Month, Day, Year)

20720

April 01 2005

		1 - For State Registrar		of Maryland / D	Certificate of			g. No.) () ()	1 17 24
Physic	ian	1. Decedent's Name (First, Midd	die, Last)				2. Date of Deatl		3. Time of Death
/Med		VERNON JOSEF			1 0. 7		APRIL	12, 2005	12:15 A
Exam	ner	4a. Facility Name (If not institution STELLA MARIS		umber)		or Location of Death ONIUM		4c. County of D	
Funera		5. Social Security Number	6. Sex	7. Age (In yrs. last birtl		If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Fore Country)
Directo		213-07-3380	1⊠M 2□F	86 Y	rs. Wortins Days	Tiodis Will.	8/25/19	18 M	ARYLAND
M I		Usual Residence of Decedent 10a. State 10b. Count	dy	10c. City, Town	or Location				10d. Inside City Lim
ms 23a or 28a-f show	io	MD BALT	IMORE	GLEN	ARM				1 □ Yes 2 🟋
or 28	Completed by Funeral Director	10e. Street and Number	AD		10f. Zip Code		10	g. Citizen of What	Country?
8 23a	gra	12912 KANES RC		cedent Ever in U.S.	21057		anifu Van as Na	USA	merican Indian,
r Item	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed F arried 1 ☐ Yes	Forces? 2 (X) No	13. Was Decedent of If Yes, specify Cub		Rican, etc.)		/hite, etc.
wittin /2 nours after ene. than "natural", or Ite te Medicel Evanina	l by	3 X Widowed 4 ☐ Divorce	ed If Yes, G Year or	dive Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	WHITE
natu	etec	15. Decede (Specify only high	ent's Education est grade completed	16a.	Decedent's Usual Occu Give kind of work done	during most of work	ing	6b. Kind of Busine	ss/Industry
al Hygiene. I other than "	dwo	Elementary/Secondary (0-12) 7TH GRADE	College	(1-4or 5+)	life. DO NOT use retire ACHINIST	30)		CAN COMPA	ANY
dther other	Be C	17. Father's Name (First, Middle	a, Last)			18. Mother's Name			
is faint. School when the pries within 12 hours are local with the waryar is faint and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eventinar must be notified at	To	LEWIS SMITH				EMMA SM	ITH		
h and 7 Is m		19a. Informant's Name/Relation ESTHER MATULON			Mailing Address (Street			-	
Healt Healt Hem 2		20a. Method of Disposition	ILS/ DAUGHT.	20b. Place of	916 PINE KN Disposition (Name of		ELDERSBU	NG, MD a	21784 or Town, State
ent of nt: If I		1 ☐ Burial 2 🛣 Cremation 1 ☐ Donation 5 ☐ Other (n State	. crematory or other pla CREMATORY ,	1 1	6/2005 0	ATONSVILI	E MD
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Signature of Funeral Service		ТЪПО					HOME, P.A.
8 8 E 8 8		1				H RAVEN BL			21286
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	company the dense Dense					
			st only one cause on	each line.	t enter the mode of dyi	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
		Immediate Cause (Final disease or condition resulting in death)	a. GAS	each line. [ROINTESTINA	L BLEED	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
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		1 - For Sta	· ·	artment of Health and Martificate of Death	Mental Hygiene	005 10700
Physic /Med		Decedent's Name (First, Middle, Last) SYLVIA		SOLOMON	2. Date of Death APRIL 11, Day	3. Time of Death 2:49 A M
Exami		4a. Facility Name (If not institution, give street 3000-E FALLSTAFF MA		4b. City, Town, or Location of Death	RE	County of Death N/A
Funera Directo		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 02/11/1910	Birthplace (State or Foreign Country) MD
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City, Town or Lo	ocation	- 14 ·	10d. Inside City Limits 1 X Yes 2 □ No
with the Marylan to or 28a-f show	Director	10e. Street and Number 3000-E FALLSTAFF MA		10f. Zip Code 21215	10g. Citi	izen of What Country?
be filed within 72 hours after death with the Maryland half Hygiene. In a char then "naturel", or Items 23s or 28s-f show event, Ite Marical Examiner must be notified at	by Funeral	11. Marital Status 12. W AI 1 Never Married 2 Married 1	as Decedent Ever in U.S. 13. med Forces?	Was December of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
of the within 72 ho if Hygiene.	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) FTSMAN	king	ond of Business/Industry
e d ai	To Be C	17. Father's Name (First, Middle, Last) ABRAHAM	ROCHKI		ne (First, Middle, Maiden	Surname) ROCHKIND
2 sho and and ls m		19a. Informant's Name/Relationship (Type, P. LAWRENCE SOLOMON / S	ON 11 K	ng Address (Street and Number or Ru EYSER WOODS CT. B	ALTIMORE, MI	D 21208
2 8,2 ≒ 5		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cometer Cre ANSHE EMU	NAH AITZ 04/1	2/2005 BAL	ocation - City or Town, State TIMORE, MD
permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Licensee	Alle 8	ONG and Address of Facility SO 900 REISTERSTOWN	L LEVINSON A	& BROS., INC. SVILLE, MD 21208
Physician	_	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	ise on each line.	ter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
/Medica Examiner		ſ	Due to (or as a consequence of): Due to (or as a consequence of):			
of ou, rate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
fficate be e physician as the buria	ical	d				
The Law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	hysician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
w requires that the been signed by should be detac	by P	Part II. Other significant conditions contribut	ing to death but not resulting in the u	underlying cause given in Part I.		use contribute to the cause of death?
	Completed				24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Physicien: The Irthis certificate his	To Be	25. Was case referred to medical examiner? 1 Yes Hospit	1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing H	ath (Check only one)	
- 5 e	ertification:	1 Natural 5 Pending 2 Accident investigation	a. Date of Injury 28b. Time of (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injur	
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	O	4 Homicide determined	e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, State	
the Hosp hin 24 ho the Fune mpletely (Medical	(Check only 2 Medical Examiner: (one)	1: To the best of my knowledge, dealed the basis of examination and/or indicated manner stated.	th occurred at the time, date and place evestigation, in my opinion, death occu-	irred at the time, date and	d place, and due to the cause(s) te signed (Month, Day, Year)
To To	-	29b. Signature and title of certifier		Dag 1931	7 4	(111)
10		BORTS KERTHER	ted cause of death (Item 23a) (Type	Print) RENETATE AS	BALTIMOR	ur, nD 2,208
. S	tate	31. Date filed (Month, Day, Year)	32. degistrar's Signature	miles		

State of Maryland / Department of Health and Mental Hygien For State Registra Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (Eirst, Middle, Last) **Physician** 300 M US otu /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** rasclis Hru Medica Center tone If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. 79 1925 Michigan Director 424-22-8726 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits s 23a or 28a-f show ty Yes 2 □ No <u> Maryland Anne Arundel</u> Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 IIS A 508 Royal Street filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: δ Widowed 4 □ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is markad other than Elementary/Secondary (0-12) College (1-4or 5+) IRS 12th 0 Examiner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Finley Theresa Howard 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 Is any injury or other trau Lannette Wheeler (Daughter) 10 F Greystone Ct. Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/5/05 ' 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Reese West st. Sons Mortuary, Annapolis, Md Larry B. Beese MC0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mesenteric hows 18 cheme disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, juisease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thipatient 2 ER/Outpatient 3 DOA 10 this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To tha Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0056208 7/05 July MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 purh oar's lecter MD cal parker 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2005 Registrar

			1 - State of Maryland		artment of Hertificate of E		-	ene g. No.2 0 0 5	12740
	Physici		1. Decedent's Name (First, Middle, Last) DOROTHY	SC	HNEIDERMA	N	2. Date of Death	Day O Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL		4b. City, Town, or BACTIA	10RE	-177	4c. County of Dea	N/A
	Funeral Director		5. Social Security Number 086-40-6577 Usual Residence of Decedent	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day, SEP . 24,	1909 9. Bi	rthplace (State or Foreign lountry) POLAND
	a-f show	ctor	10a. State 10b. County 10c. City, 1		TIMORE				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the 23a or 28	ral Director	10e. Street and Number 11 SLADE AVENUE #803		10f. Zip Code	21208		g. Citizen of What C	USA
336	urs after de st', or itemé	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🏋 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or iteme 23s or 28s-4 show other traumatic event, the Medical Examiner must be nullified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired) IEMAKER	uring most of worki	ing 1	6b. Kind of Business	s/Industry
	ould be filed with Mental Hygiene arked other than attc event, Ire	To Be Cor	17. Father's Name (First, Middle, Last) ABRAHAM		DSTEIN	18. Mother's Name			(UNKNOWN)
, Maryland	1 and 2 should Health and Men em 27 is marke ither traumatic	F		19b. Mailir	ng Address (Street a	nd Number or Rura	al Route Number,	City or Town, State,	Zip Code)
altimore,	Page nent c ant: M ury or		1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	l MOSI	osition (Name of matory or other place ES CEMETER	RY 04/13		Oc. Location - City o	
Bal	permit. Departr Imports any ing		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death.	1,10		TERSTOWN	ROAD -	SON & BROS PIKESVILL	•
	Pnysician /Medical		shock, or heart failure. List only one cause on each line.	IVE	RESPI				Interval Between Onset and Death 2 Locus
	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		SGE				12 hours
8760, <	cate be executed physicien and the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequent	nce of):					
. Box 687	death certiticate e attending phy d tor use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 m/nths? 1 Yes 2 No	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
ls, P.O	res that the de signed by the a libe detached i	by	Part II. Other significant conditions contributing to death but not resulting		nderlying cause give	n in Part I.			to the cause of death?
Records,	The law requires that the death certiticate has been signed by the attending page 2 should be detached for use as	Completed	RTMAL FEBRILLA	510		2	24a. Was an autopsy	24b. Were a prior to death?	utopsy findings available completion of cause of
of Vital	Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 Yes Hospital: 1 Inpatient 2 EP	VOutpatier	nt 3 DOA Othe	26. Place of Death	(Check only one) ace 6 Other (Spe	acify)
Division	or Attanding Ph fler death. Virector: After th n by the funeral	Certification:	1 Matural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	Injury e, farm, str		'es 2 □ No	28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,
J	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle and manner stated.	edge, deat n and/or in	h occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the cau ed at the time, dat	use(s) and manner a le and place, and du	s stated. e to the cause(s)
	To ti withii To ti comp	W	29b. Signature and title of certifier		29c. License			d. Date signed (Mon	th, Day, Year)
	3		30. Name and address of person who complete cause of death (Item 2:	MD	S/A	A/ H	03415	AL	
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 4 2005 32. Jegistrar's Signafur	4	andi)				

216-42-0138 IEM 2 F 61 Yrs. Months Days Hours Min. (Month, Day, Year) Months Days Hours Min. (Months Days Months Days Hours Min. (Months Days Months Days Day	
Morris J. Snowden Anne Arundel Medical Center Annapolis Anne Arundel Medical Center Annapolis Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 10 Maryland Anne Arundel 10 Maryland Anne Arundel 10 Maryland Anne Arundel Annapolis Annapolis 10 Maryland Anne Arundel 11 Marial Status 11 Marial Status 12 Was Decedent Ever in U.S. 13 Was Decedent Origin? (Specify Yes or No- 14 Wes, Give 14 Marial Status 15 Specify 16 Marial Status 16 Marial Status 17 Kes, Give 17 Marial Status 18 Marial Status 19 Wes Specify Cuban, Marcian, Puerfor Indian, etc.) 19 Marial Status 10 Marial Status 10 Marial Status 10 Marial Status 11 Marial Status 11 Marial Status 12 Was Decedent Ever in U.S. 13 Was Decedent Origin? (Specify Yes or No- 14 Marial Status 16 Marial Status 17 Marial Status 18 Marial Status 19 Wes, Give 19 Marial Status 19 Marial Status 10 Marial Status 10 Marial Status 10 Marial Status 10 Marial Status 11 Marial Status 11 Marial Status 11 Marial Status 12 Was Decedent Ever in U.S. 13 Was Decedent Origin? (Specify Yes or No- 14 Marial Status 16 Marial Status 17 Marial Status 18 Marial Status 19 Marial Status 10 Marial Ma	3. Time of Death
As. Facility Name (if not institution, give street and number) Anne Arundel Medical Center Anne Arundel Medical Center Anne Arundel Medical Center Social Security Number 16. Sox 1 Social Security Number 216-42-0138 Usual Residence of Decedent 106. South 106. Sox 1 Social Security Number 216-42-0138 Usual Residence of Decedent 106. South 106. Sox 1 Social Security Number 216-42-0138 Usual Residence of Decedent 106. South 106. Sox 1 Social Security Number 216-42-0138 Usual Residence of Decedent 106. South 107. Social Security Number 216-42-0138 Usual Residence of Decedent 106. South 107. Social Security Number 216-42-0138 Usual Residence of Decedent 106. South 107. Social Security Number 216-42-0138 Usual Residence of Decedent 106. South 107. Social Security Number 216-42-0138 Usual Residence of Decedent 107. Social Security Number 216-42-0138 Usual Residence of Decedent 107. Social Security Number 217. Age (In yrs. last birthday) 108. Town or Location Monthly Days Hours Min. Social Security Number 218-42-015 109. Social Security Number 219-5-18-18 109. Social Security Number 109. Social	5 1400 M
Anne Arundel Medical Center Annapolis Anne Arundel Medical Center Annapolis Anne Arundel Medical Center Annapolis Anne Arundel Medical Center Annapolis Anne Arundel Medical Center Annapolis Anne Arundel Medical Center Annapolis Annap	
Social Security Number S. Sex 12 Maria State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. City, Town or Location 100. State 100. County 100. City, Town or Location 100. City,	undol
Director 216-42-0138 12M 2 F 61 12 13 14 15 15 15 15 15 15 15	ntholace (State or Foreign
Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 10d. Zip Code 10g. Citizen of What C 2045 Forest Drive 2045 Forest Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Race Am 15 Specify Yes on No. 11. Marital Status 1 Never Married 20 Married larvland	
Eugene Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Rosa Lee Snowden (Wife) 20a. Method of Disposition 1	-
Eugene Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Rosa Lee Snowden (Wife) 20a. Method of Disposition 1	10d. Inside City Limits 11€ Yes 2 □ No
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Eugene Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Rosa Lee Snowden (Wife) 20a. Method of Disposition 1	ountry?
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Eugene Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Rosa Lee Snowden (Wife) 20a. Method of Disposition 1	:/Industry
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Eugene Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Rosa Lee Snowden (Wife) 20a. Method of Disposition 1	Marvland
Rosa Lee Snowden (Wife) 20a. Method of Disposition 1	1
Rosa Lee Snowden (Wife) 20a. Method of Disposition 1	
Cosa Lee Showden (Wife) 20b. Place of Disposition (Name of John City of Annapolis 20c. Location - City of Annapolis 20c. Method of Disposition 1	Zip Code)
A Donation S Other (Specify) Neck Cemetery 4/8/05 Annapolis	21401
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, and any, leading to immediate.	Town, State
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, and any, leading to immediate.	, Md.
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, and any, leading to immediate by the conditions of the con	
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of).	
/Medical Examiner Sequentially list conditions, if any, leading to immediate by the sequence of the sequence	Approximate Interval Between Onset and Death
Examiner Sequentially list conditions, and any, leading to immediate Due to (or as a consequence of): b. Courto (or as a consequence of).	Oriset and Death
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of).	
The standing to minimize the standard cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of):	
that initiated events fresulting in death) Last c. Due to (or as a consequence of):	
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O the policy of	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.	the cause of death?
1 Yes 2 Ho 3 P	robabiy 4 Dunknown
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I. 1 Yes 2 Ho 3 P 24a. Was an autopsy performed? death? 1 Yes 2 No 1 P 24a. Was an autopsy performed? death? 1 Yes 2 No 1 P	utopsy findings available
Y = 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	completion of cause of
To the control of the	
W = 0 11 VAS 2 2M0	icify)
27. Manner Death 28a. Date of Injury 28b. Time of Injury 4 Nursing Home 5 Hesidence 6 Other (Spe	
O	
27. Manner Death Comparison of the property	ural Route Number,
The statutal	s stated. e to the cause(s)
one) and manner stated. 29c. License number 29d. Date signed (Mont)	th Day Year)
F 3 F 8	7 7 0 01
TO THE COUNTY TO THE PARTY	1,2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	m
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar APR 1 4 2005 Server A	l

			1 - State of Maryland /	Department of Certificate of		lental Hygier	2005 10310
ı	Physici		1. Decedent's Name (First, Middle, Last) Dorothea P	Stamper		2. Date of Death	Day Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Northwest Hospital	4b. City, Town,	or Location of Death	1	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 231-30-0015 6. Sex 1 □ M 2 □ F 81 Usual Residence of Decedent	birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Yes 5-12-192	9. Birthplace (State or Foreign Country) NORTH CAROLINA
	Maryland a-f show	tor	10a. State 10b. County 10c. City, To	TIMORE			10d. Inside City Limits 1
	vith the	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Country?
99	72 hours after death with the Maryland Insturel', or items 23a or 28a-f show diest Exacelher out be rediffed at	/ Funeral	3811 FAIRVIEW AVE • 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedenf Ever in U.S. Armed Forces? 1 □ Yes 2 □ Wolf Yes, Give Year or Dates:	2121 13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Spr uban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: BLACK
215-0036	olo 72 hours in "naturel", Medical Ext	Completed by		6a. Decedent's Usual Occ	upation ne during most of work	ing 16b.	. Kind of Business/Industry
2121	filed within Hygiene. other than "	Com	-60- C	ERTIFIED NUR	T		HEALTHCARE
Maryland	s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene. Item 27 is marked other than "natur other treumetic event, Ira Madical	To Be	17. Father's Name (First, Middle, Last) CHARLIE PERRY		18. Mother's Name	AUSTIN	len Sumame)
	and 2 sho lealth and m 27 is m						ty or Town, State, Zip Code) IARYLAND 21216
Baltimore,	00		1 X Burial 2 Cremation 3X X Removal from State	o of Disposition (Name of etery, crematory or other p TEPHENS CEME	lace)		. Location - City or Town, State RENTON NORTH CAROLIN
Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of June of Service Lieensee JONATHAN D. HI.				ERAL HOME, P.A. IORE, MARYLAND 21217
	Purysician and Medical Examiner	al Examiner	23a. Part1. Efter the disease, or complications that caused the death. Dishcok, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or conditions). Due to (or as a consequence or conditions).	adenocare coop): ce of):	,		Approximate Interval Between Onset and Death Month S
P.O. Box 687	The law requires that the death certificate be executed tte has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea	ath 3 □Ectopic pregnar			23d. Date of delivery Month Day Year
ecords, P.	quires that in signed bi uld be deta	by	Part II. Other significant conditions contributing to death but not resulting End stage renal disease	g in the underlying cause (given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
		Completed	•			24a. Was an autopsy performed 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
f Vital	ysic s ce direc	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 N No Hospital: 1 ☐ Inpatient 2 SER/	Outpatient 3 DOA)then	n <i>(Check only one)</i> me 5 ☐ Residence	6 ☐Other (Specify)
Division of	tending eath. or: After the funer	Certification;	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 288. Place of Injury - At home, building, etc. (Specify)		Yes 2 No	28d. Describe how in 28f. Location (Street City or Town, St	and Number or Rural Route Number,
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier (Check only Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination				
	To the within 2 To the complei	Medical	29b. Signature and title of certifier Description 30. Name and address of person who completed cause of death (Item 23 5 400 01d Count Road Sud 31. Date filed (Month, Day, Year) APR 1 4 2005	29c. Lice	35844	29d. 1	Date signed (Month, Day, Year)
_	15		30. Name and address of person who completed cause of death (Item 23 5400 Old Court Road Sui	a) (Type, Print) Te 108 R	2 and all ston	un ma	2//33
	Sta Registi	4.7	31. Date filed (Month, Day, Year) APR 1 4 2005 32 Regisfrar's Signature	Sperle			

				artment of Health and Me rtificate of Death	ntal Hygien	2005 1001 -
П	Physici	an	Decedent's Name (First, Middle, Last) ANDREW KEITH TALBOTT		Date of Death Month APRIL 12,	3. Time of Death 11:50 AM
	/Medio	cal	ANDREW KEITH TALBOTT 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Examir	ler	LAUREL REGIONAL HOSPITAL	LAUREL		PRINCE GEORGES CO
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 218-67-0289 Type 1 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. S	Date of Birth (Month, Day, Year ep 7, 20	9. Birthplace (State or Foreign Country) Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	peation		10d. Inside City Limits
	Maryl 4 sho	to	MD Prince George's Laurel			1□Yes 2□No
	th the	Director	10e. Street and Number	10f. Zip Code	10g. C	litizen of What Country?
	23a c		14707 Bowie Road #103	20708		.S.A.
36	iges 1 and 2 should be filed within 72 hours atter death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28e-f show or other traumetic event, it is Madical Examiner must be notified at	by Funeral	12XNever Married 2 ☐ Married 1 ☐ Yes 2XXNo	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes ②CX No Specify:	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	72 hou nature	sted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b.	Kind of Business/Industry
21215-0036	within lene. than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		/>
	filed v Hygie other t		N/A 17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maide	
Maryland	ould be Mental arked o	To Be	Alan M. Talbott	Nadia J. R	adjiman	
lary	2 should and Men is marke aumetic			ng Address (Street and Number or Rural F	-	
	1 and lealth sm 27 lher tr				aurel, Ma	aryland 20708 Location - City or Town, State
nor	Pages nent of H int: If ite iry or of		Lixingurial 2 Cremation 3 metitoyaritoni state	position (Name of matory or other place) Mem. Park 4/18/2		criottsville, MD
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee	2 Name and Address of Facility Onaldson Funeral Ho 13 Talbott Avenue	me, P.A.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Asphyxia		Onset and Death
8760,	death certilicate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
O. Box 6	death certiti e attending I id for use as	Physiclan/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	es be	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		use contribute to the cause of death?
Il Records,	The law ate has b page 2 si	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital	Physician: Th this certiticate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (C		
of	0 S	To :	27 Manner of Death 28a, Jate of Injury 28b, Time of	of 28c. Injury at 28c	5 Aesidence d. Describe how inj	6 ☐Other (Specify) ury ogcurred , .
lon	Attending I r death. ector: After by the funer	atlor	1 □Natural 5 □ Pending Month Day Year) Injury 2 Ccident investigation	Work? 1 □ Yes 2 No	enetical	stanted in
Division	I or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28 Place of Injury - At home, farm, st building, etc. (Sp—ify)	reet, factory, office 28f	Location (Street a City or To	
	urs afte		AT Ito		1707 60	s) and manner all stated. 2070
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely tilled in by the funeral	Medical	29a. Certifier (Columbia of the control of the co	in occurred at the time, date and place, and experiment in my opinion, death occurred	at the time, date ar	
	To the Hospital within 24 hours a To the Funeral to completely tilled	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
)	0		(Corpell)	OCME	APR	IL 13, 2005
1	-		30. Name and address of person who completed cause of death (Item 23a) (Type,	111 Penn Street	Baltimo	re, Maryland 21201
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 4 2005 32. Registrar's Signature	barke		

			1- State Amend Item 8 per rh, 6845,0//29/05ahb Certificate of Death	Mental Hy	
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath 3. Time of Death
	Physic		Rosalina Martin Townsend	APRIL	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Death
	-xaii		CIVISTA MEDICAL CENTER LA PLATA, MAR	YLAND	CHARLES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birt	
	Director		579-50-8286	07/27/1	938 Washington, DC
	p		Usual Residence of Decedent		
_	aryla shov	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
5)	8a-f	cto	MD Charles Waldorf		1 M Yes 2 No
Q	or 2	100	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
5	ath v	Funeral Director	24 Amwich Court 20602		U.S.A
Q_{j}	er de Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
38	s aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: Year or Dates:		Specify: TII
5-0036	hour turai	pa	15. Decedent's Education 16a. Decedent's Usual Occupation		White
215	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo	rking	16b. Kind of Business/Industry
20212	I with iene.	l lo	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Home
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Eraci, for interfer rediffed at	Be C		me (First, Middle,	Maiden Sumame)
1 <u> </u>	ild be lenta rkad ic ev	To B	Thomas Arabijo Marmito Minnie	e Eleanor	Martin
Maryland	d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maillan Eran ther minister rediffed.	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re	ural Route Numbe	r, City or Town, State, Zip Code)
Q) ≥	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Mportant: If item 27 is marked other than any injury or other traumatic event, Item Manca.		Thomas D. Townsend, Jr. Son 11345 Maiden Bower Pl	., La Pla	ata, MD 20646
ري <u>چ</u>	nit. Pages 1 and artment of Heali ortant: if item 2 injury or other 8.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
OE	Pages nent of I int: if it		1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery Apri	1 1/4 2005	Suitland MD
ROS Baltimore	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ee Funera	of Home Inc
G W	Per				d., Clinton MD 20735
	φ ⁰		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):		
	Examiner		Dr. Oldina		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of):		
V	te be executed ysician and te burial-transit	Examiner	Cause (Disease or injury that initiated events		
ó	an an rial-tr		resulting in death) Last Due to (or as a consequence of):		
760,	W 22 00	cal	d		
Box 68	leath certificat attending phy I for use as th	Med			
ŏ	th cer endir r use	J.V.	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
	that the death	sicle	1 Tyes 27 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
P.O.	at the by the	hys	a Couklowu		
- Ś	res the	by Physiclan/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
ord	w requir been si should I			1 🗆 Y	es 2 🖼 No 3 🗌 Probably 4 🗍 Unknown
ပို့	e law n has be je 2 sh	Completed		24a. Was a	
œ	The ate ha	mo		autops perform	ned? death?
<u> </u>	ician: Th certificate rector, pag	Bec	25. Was case referred to medical 26. Place of Dec	ath (Check only on	
=	nysic nis ce direc	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing F	lome 5 Reside	ence 6 Other (Specify)
0	iding Physician: th. After this certifical tuneral director, I	ü	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe ho	ow injury occurred
<u>.</u>	ttandir death. ctor: Al y the fu	atlo	2 Accident investigation M 1 Yes 2 No		
Division of Vital Records,	il or Attanding Physician: The law requires that the death certifica after death. I Director: After this certificate has been signed by the attending ph d in by the funeral director, page 2 should be detached for use as the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	reet and Number or Rural Route Number, n. State)
	rs aff				,,
	dosp t hon unel	cal	29a. Certifier (Check only application) (Ch	, and due to the ca	ause(s) and manner as stated.
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	and manner stated.		
	To To	~	29b. Signature and title of certifier D-52289	2	9d. Date signed (Month, Day, Year)
			1 / ach 1 / ach		4/11/2005
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	2		MATHUR, NALIN, MD 10 SAINT PATRICKS DRIVE WALDO 31. Date filed (Month, Day, Year) 32. Registrar's Signature	RF, MAR	YLAND 20603
	Sta Registr				
		¥	APR 1 4 2005 Real M. Society		

			1 - For State Registrar	• •	ryland / De		t of H	ealth a	nd Mental H		9005	1271	+5
	Physici	an	1. Decedent's Name (First, Middle, L Pear1	ast)	-	Thomas			2. Date of I Month April		2005 Yea	3. Time of E 1.850PM	
	/Medic		4a. Facility Name (If not institution, g				Town, or	Location of			c. County of De		
	Examili	er	Harley Hall Nur					ke Cit			Worces	ter	
	Funeral Director		5. Social Security Number 6. 213-24-2719	Sex 7. Age 1 M 2 G F 8 5	(In yrs. last birthda	Months	1 Year Days	If Under 2 Hours	Min. 8. Date of E (Month, 1 May 2	Sirth Day, Year	9. B 19 Ma	irthplace (State or Country) ryland	Foreign
	pu »		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	Location						10d. Inside City	Limite
	Maryla f sho	or	Maryland Somerse	.	Prince		0					1 Tes	
	r 28a-	rect	10e. Street and Number		TITICE	10f. Zip				10g. C	itizen of What (Country?	Λ
	th with	al D	30121 Deal Isla	nd Road		2	1853				U.S.A.		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Exam, and must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent BARMed Forces? 1 Yes 2 Y N If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - An Black, Wi Specify:Wh	nite, etc.	
5-0	72 ho 'netur	eted	15. Decedent's (Specify only highest of	Education rade completed)	16a. De (Gi	cedent's Usua ve kind of wor b. DO NOT us	l Occupa k done d	ation Juring most	of working	16b. I	Kind of Busines	s/Industry	
121	within ane. than	ldw	Elementary/Secondary (0-12) 7 th	College (1-4or 5	+)	. <i>DO NOT us</i> Iemaker)			Home		
d 2	filed Hygie other ent,	e Co	17. Father's Name (First, Middle, La.	st)	11011	lemaker		18. Mother	's Name (First, Midd	le, Maide			
lan'	fental fental rked ric ev	To Be	Benjamin	${ t Kidwell}$				Eliz	abeth	Во	oswell		
lary	and N	-	19a. Informant's Name/Relationship			-			or Rural Route Num				
≥,	and sealth m 27		Mary J. Warren	(Daughter)					oad Prince	1			
Baltimore,	iges 1 nt of H : If ite or ot		20a. Method of Disposition 1 XBurial 2 Cremation 3		20b. Place of Dis			,	pril ^{ate} 7,		Location - City o		
I ir	iit. Pa artmer ortant injury		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Resurre				2005 Lee Fun			Maryland	
Ba	Depa Impo any is		1.4.001	/ / .	0153				ndria Fer				735
			23a. Part1. Enter the disease, or co shock, or heart failure. List on									Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	00	ment	à						Onset and De	eath
1	/Medical Examiner		resulting in death)	d	a consequence of):				<u> </u>				
	·	-	Sequentially list conditions,	b. Due to for as	a consequence of								
./	ned Insit	nlne	Sequentially list conditions, it arry, leading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events	, , , , , , , , , , , , , , , , , , ,	a sample que la compa								
, \	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):								
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.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pri 5 □ Other (spi					23d. Date of d Month	elivery Day Ye	ear ear
<u>α</u>	The faw requires that the tite has been signed by thoage 2 should be detached.	y Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying ca	ause give	en in Part I.	23e. Did	d tobacco	use contribute	to the cause of de-	ath?
Records,	quires an sign	Completed by	Kenel	failure					1	Yes 2	2 □ ₩ 3 □	Probably 4 🗆 Un	iknown
ဝ၁	as bee	plet							24a. Wa	is an	24b. Were	autopsy findings av	vailable use of
Ä	(0)	Com							pe 1 ☐ Yes	formed?	death'	es 2 No	300 01
Vital	ding Physician: h. After this certifications of the director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	-	of Death (Check only				
of	Phy this ald	1: 10	1 Yes 2 No	1 🗆 inpatie	nt 2 ER/Outpai		/A	4 (3) (40)	sing Home 5 Re			ecify)	
n	Attending r death. sctor: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of Injui (Month, Day	Year) Injur	M	8c. Injury Work 1 🗆 \	(? Yes 2 □ N			,		
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, farm, c. (Specify)	street, factory	, office			(Street a own, Sta		Rural Route Numb	er,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical C		Physician: To the best of aminer: On the basis of aminer sta	examination and/or								
	To the within To the comp	Me	29b. Signature and title of certifier	Zavol		290	. License			29d. D	ate signed (Mo	1	
			•			-0.5	-	-44			4-2-	- 05	
	4		30. Name and address of person wh	o completed cause of d Ket St	eath (Item 23a) (Type	oe, Print) S	arac	bava	MD	21	851		
	Sta		31. Date filed (Month, Day, Year)		ar's Signature		-						
	Regist		APR 14	2005 See	w B	Growth.	0						
DH	MH 17 Rev 1/2	001			ORIGIN	VAL							

			1 - For State Registrar AMEND ITEM#5						nd Mental H		400	5 12	2746
	Physici		Decedent's Name (First, Middle, Last) Mable Tyndall	FER_ANA	DD G 04	Z4/-[4	703.JE		2. Date of I		Day Yes	ır_	ne of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or Lo	ocation of	Death	-	4c. County of D		130.
			Peninsula legin	sal Ned	in/ Cent	ber -	Solie	shur			Wicon	nin	
	Funeral		5. Social Security Number	7. Age	e (In yrs. last birth	nday) If Under Months		Under 2	Min. 8. Date of E	Birth	9. 1	Birthplace (St	ate or Foreign
	Director		222-56-7784	M 2X1F	73 Y	rs.	Days	riouis	Mar 9	19	32 1	Country) Delawai	re
	pur *		Usual Residence of Decedent 10a. State 10b. County		10a City Town	on Longton							
	sho	<u>_</u>	MD Wicomico		10c. City, Town	1mar							le City Limits
	he M	Director											Yes 2X No
	ours after death with the Marylan ral', or Itams 23a or 28a-f show Examiner must be notified at	Dir	10e. Street and Number			10f. Zip				10g. (Citizen of What	Country?	
	s 23g	Funeral	4 W. State Street				218				USA		
	er de Itam	une		2. Was Decedent I Armed Forces?		13. Was Deced	ent of Hispa ify Cuban, N	anic Origi Mexican,	n? (Specify Yes or f Puerto Rican, etc.)	10-	14. Race - A Black, W		n,
36	rs aft	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10	1 ☐ Yes	No S	Specify:			Specify:	white	<u>!</u>
21215-0036	72 hours after death with the Maryland neturel', or Itams 23a or 28a-1 show dical Examiner must be notified at		15. Decedent's Educ		162 [Decedent's Usua	I Occupatio	nn.		166	Kind of Busine	os/lodustar	
15	d within 72 ho piene. r than "natur tha Medical.	Completed	(Specify only highest grade	completed)	(Give kind of wor	k done duri	ing most o	of working	100.	Kind of busine	ssindustry	
72	l within iene.	mo l	Elementary/Secondary (0-12) unk u1	College (1-4or 5 nk	+)	dis	abled				none		
ğ	ill Hygi other	e)	17. Father's Name (First, Middle, Last)				-	3. Mother	s Name (First, Midd	le, Maid			unk
a	should be nd Mental markad c matic ava	To B											ank
Maryland	" = m =		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b.	Mailing Address	(Street and	/ Number	or Rural Route Num	ber, City	or Town, State	, Zip Code)	unk
	and 2 ealth a n 27 is		Darlene Horseman/c	aregiver									
ē,	of Heal		20a. Method of Disposition		20b. Place of I	Disposition (Name, crematory or of	e of		Date	20c.	Location - City	or Town, Stat	е
Ë	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 🕅 Other (Specify)	emoval from State in state	1	, crematory or or	ner piace)	į					
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Euneral Sovice License Rona		/	State and	arton	f Eacility	ard 655 W	. Ba	ltimore	Stree	t
	TO 2 6 0		Junua 1	40	ee_	Baltimo			1201				_
	15		23a. Part Enter the disease, or compli- shoot, or heart failure. List only on	e cause on each lin	the death. Do no	t enter the mode	of dying, s	such as ca	ardiac or respiratory	arrest,		Approxi	Between
	Physician		Immediate Cause (Final disease or condition		CAI)						Offset a	ind Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
	- Xammer	_	Sequentially list conditions, b										
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Fju.)	Due to (or as	a consequence of):							
	and I-tran	Examiner	that initiated events resulting in death) Last	Due to for as	a consequence of	١.							
8760,	cate be executed physician and the burial-transit			Due 10 (01 a3 t	x consequence or	,.							
87	phys the	Physician/Medical	d										
9 X	death certific e attending p d for use as i	₩e	IF FEMALE:	3c. If yes, outcome	of pregnancy								
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 ☐Ectopic pre					23d. Date of d Month	lelivery Day	Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (spe	ecify)					,	
Δ.	The law requires that the de ite has been signed by the a bage 2 should be detached f		Part II. Other significant conditions con	tributing to death by	ut not resulting in t	he underlying ca	use given in	n Part I	23e Did	tohacco	use contribute	to the cause	of death?
ds,	signi d be	d by	CHE		······································		g c	.,, .		Yes			Numknown
Vital Record	w require been sig should b	Completed	Ventricu	Le Tu	Service of	is /=	to all f	1 200					
ě	The law cate has page 2 s	mpl	VENTILLA	100 100	Myconc	(14)	brilla	Mar	— aut	s an opsy formed?	24b. Were prior to death	autopsy findir o completion	igs available of cause of
<u></u>	(0	S			_				1 ☐ Yes				
Ë	ician certif	Be	25. Was case referred to medical examiner?	ospital:			0.4		f Death (Check only				
	Attending Physician: r death. actor: After this certific. by the funeral director,	2	To tes 2 No	1 Inpatiei					ing Home 5 Res			ecity)	
E C	ting After funer	o	27. Manner of Death 1. □Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Tir Year) Inji		lc. Injury at Work?		28d. Describe	how inj	ury occurred		
<u>S</u>	ttendi death. stor: A	icat	2 Accident investigation 3 Suicide 6 Could not be	On Disease line	a. Albama fa	M		2 □ No		/C+			
Division of	after Dirac	Certification:	4 Homicide determined	28e. Place of Inju building, etc	. (Specify)	i, street, ractory,	Office		City or To		and Number or . te)	Hurai Houte N	ium ber,
	ospital hours a uneral I ly filled		29a. Certifier 1 Certifying Phys	icien: To the heat	f my knowledge	doath ann		date a : -	place and different		a) and		
	I 4 II 0	Medical	(Check only one)	er: On the basis of and manner sta	examination and/	or investigation,	in my opinio	on, death	occurred at the time	date a	s) and manner nd place, and d	as stated. ue to the caus	60(S)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier				License nu			29d. D	ate signed (Mo	nth, Dav. Yea	r)
)	⊢s⊢ŏ		While))						EI	1 die		
			30. Name and address of person who cor	nnlated cause of de	ath /Itom 22=\ C	uno Print)	1750	11/		4	3/01		
			Chris Shyde, M.	b. Inn	E MARK	01/ .51		30/13	sburg ms				
	Sta	e		2. Registra	r's Signature	1							
	Registr		31. Date filed (Month, Day, Year) APR 1 4 2005	Hera	E CANK	and I							

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 1	2747
	Physic /Medi Exami	ical	1. Decedent's Name (First, Middle, Last) A. Pacility Name (If not institution, give street and number) 2. Date of Death Month Day Year 4b. City, Town, or Location of Death 4c. County of Death	Time of Death A
	Funeral Director		249-10-9817 82 13-1922 SOUTH (C	(State or Foreign
	with the Maryla s or 28a-f show	Funeral Director	MD • N/A BALTIMORE 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Inside City Limits 1 ∰Yes 2 ☐ No
036	urs after death v ei', or items 23e ram ner must	þ	449 E • 22ND ST • 21218 USA 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 1 □ Ves 2 ☒ No If Yes, Give Year or Dates: 1 □ Yes 2 ☒ No Specify: Specify: BLACK	
121215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or items 23e or 28e-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -11- NURSING ASSISTANT 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING NURSING	у
Maryland	2 should be and Mental le marked ore	To Be	17. Father's Name (First, Middle, Last) RUBIN BUGGS ETTA WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code BRENDA THOMPSON (DAUGHTER) 18. Mother's Name (First, Middle, Maiden Surname) ETTA WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1209 NORTHVIEW RD BALTIMORE MARYLAND 212	
altimore, I	permit. Pages 1 and. Department of Health Important: if item 27 any injury or other tr once.		BRENDA THOMPSON (DAUGHTER) 1209 NORTHVIEW RD. BALTIMORE, MARYLAND 212 20a. Method of Disposition (Name of cametery, crematory or other place) 120b. Place of Disposition (Name of cametery, crematory or other place) 120b. Place of Disposition (Name of cametery, crematory or other place) MARYLAND NATIONAL 21. Signal in a Light of Specify) 21. Signal in a Light of Specify Date of Specify Date of Disposition (Name of cametery, crematory or other place) MARYLAND NATIONAL 4-18-2005 LAUREL, MARYLAND PRINCIPLE OF SECOND CONTROL	State AND
8760,	/Medical Examiner	Ilcal Examiner	shock, or heart failure. List only one cause on each line.	ID 21217 proximate rival Between served Death
O. Box 6	the death certificate by the attending phys ached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Year
ecords, P	w requires that the de been signed by the a should be detached f	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cau 1 Yes 2 No 3 Probably	use of death?
итан жес	The larate has page 2	Be Completed	24a. Was an autopsy fir prior to completic death? 25. case referred to medical examiner? 26. Place of Death Check only one)	ion of cause of
n or	ng Phye Iter this Ineral di	ertification: To	Hospital: 1	ite Number,
ב	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	cause(s)
		Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y 29d. D	rear)
	Sta Registr		APR 1 4 2005 Morey Walter Walter Courter Baltinums, with	12CE 2/202

12;45PM April 10,2005 WALTON, BARBARA Division of Vital Records. P.O. BOX

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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			1 - For State Registrar	State of Ma	aryland /		artment of H tificate of L		•	gien Reg. N	CUUS	12748
	Physici /Medic		Decedent's Name (First, Middle, Last		arbara	Ann	Walton		2. Date of De Month April	ath Da	y Year	3. Time of Death 12:45 A ^M
	Examir		4a. Facility Name (If not institution, give Gilchrist Center	street and number)			4b. City, Town, or TOWSO			1	Baltimo	ath
	Funeral Director		5. Social Security Number 6. Social Security Number 1 215-96-7215 Usual Residence of Decedent	9X 7. Ag ☐ M 2 X F	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year) 0	irthplace (State or Foreign Country) aryland
	Maryland -f show kq al	tor	10a. State 10b. County	ltimore	10c. City, To	own or La	cation		Dı	unda	ılk	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the 3a or 28a	1 Director	10e. Street and Number	1			10f. Zip Code	21222			itizen of What C	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show amy injury or other traumatic avant. It's Midlical Evanticar must be incliffed at ODGe.	by Funeral	1807 Tyler Road 11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 250 N If Yes, Give Year or Dates:			Vas Decedent of Hi f Yes, specify Cubar □ Yes 257No					nerican Indian,
21215-0036	within 72 hou iene. 'than "natura ine Medical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5		(Give life. I	lent's Usual Occupa kind of work done d DO NOT use retired,	uring most of w	vorking		anking	
land 2	uld be filed Mental Hygi Irkad other Itic avant, I	To Be Co	12 Years 17. Father's Name (First, Middle, Last) Walter Long		J	Ba.			ame (First, Middle,	Maide		
, Mary	and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationship (7 Mr. Fred Waltor		d)	1807	g Address <i>(Street a</i> Tyler Ro	ad Dun	Rural Route Numbered	•		
Baltimore, Maryland	. Pages 1 tment of Hi tant: if itan jury or oth		20a. Method of Disposition 1 ☐ Burial 2\times cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	1	op S	sition (Name of natory or other place ervice Co	rp. 4/1	Date 2/2005		ocation - City o	r Town, State Maryland
Ba	permil Depar Impor any in		21. Signature of Funeral Survice Licen	e Ma	sey		Name and Addres a Ruck 7922 Wise	Funera Ave.	Dundalk,	Ma		21222
1	Pnysician /Medical		23a. Part1. Enter the disease, or companies shock, or heart failure. List only a limmediate Cause (Final disease or condition resulting in death)	aDue to (or as	tast.	nti	the mode of dying			rrest,		Approximate Interval Between Onset and Death
1/	Examiner is the state of the st	Examiner	Sequentially list conditions, if any, leading to immediate cause End Unerlying Cause (Disease or injury	b. — Due to (or as	a consequenc	ce of):						
8760, <	sate be executed bhysician and the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a	a consequenc	ce of):						
.O. Box 6	The law requires that the death certific tie has been signed by the atlending p bage 2 should be detached for use as	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)				23d. Date of de Month	elivery Day Year
Records, P.	w requires that been signed t should be det	by	Part II. Other significant conditions co	ontributing to death be	it not resulting	g in the ur	iderlying cause give	n in Part I.		obacco /es 2		to the cause of death? Probably 4 □Unknown
	The law rocate has be page 2 shi	Completed							24a. Was autop perfo 1 Yes	sy rmed?	prior to death?	uttopsy findings available completion of cause of s
Division of Vital	To the Hospital or Attanding Physician: Th within 24 hours attendeath. To tha Funaral Director: Affer this centificate completely filled in by the funeral director, pag	Certification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		v 28b	Outpatien Time of Injury	28c. Injury Work	r: 4 🗆 Nursing	eath (Check only on Home 5 Residence of Resi	dence		ecity) (Cipica
DIX	pital or Att ours after d aral Diract		3 Suicide 6 Could not be determined	building, etc	. (Specify)			with the N. Li	City or Tox	vn, State	e)	Bural Route Number,
	To the Hospital within 24 hours and to the Funeral completely filled	Medical		iner: On the best of iner: On the basis of and manner sta	examination.	and/or inv	estigation, in my op	inion, death oc	curred at the time,	date an) and manner a d place, and du te signed (Mon	e to the cause(s)
١	⊢ ≱ ⊢ ŏ	1	30. Name and address of person who d	my All) 1 (1)	(Type	0.25	1205	4	170	ril 10	, 2005
	D Sta	te	31. Date filed (Month, Day, Year)	6 BMC	& 70 r's Signature) j\/	- Charles	· -C+.	Balto.	Md	212	26/2
DH	Registr	ar	APR 1 4 200	39 Registra	, B.	600	W)					

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of H	lealth an Death	d Mental	Hygien Reg. N		12750
	Dhooisi		1. Decedent's Name (First, Middle, Last)					2. Date Mont	of Death	ay Year	3. Time of Death
	Physici: /Medic		KATHRYN CECILIA A						ch 27,	2005	12:20 a M
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	r Location of C	Death	4	c. County of Dea	th
			Washington Advent		for a felicitate star of	Takoma I		Hre o Date		lontgome	thplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	Yrs.	Months Days		Min. ADTI	of Birth th, Day, Yea 1 5, 1	913 Was	chington, DC
	Director		577-09-3315 Usual Residence of Decedent					1411	2 3, 1	313 1140	mangeon, bo
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	a-fsl	ctor	Maryland Prince G	eorge's Hya	ttsvi1	1e					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. 0	Citizen of What C	ountry?
	ath w	ra	4916 LaSa11e			20782				S.A.	
	hours after death with the Maryland ural', or Itams 23a or 28a-1 show al Examinat must be multibut at	Funeral	Trivialities areas	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin an, Mexican, P	? (Specify Yes Juerto Rican, et	or No- c.)	14. Race - Am Black, Whi	
30	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			Specify: [White
ş	2 hou		15. Decedent's Edu	cation	16a. Deced	dent's Usual Occup	ation		16b.	Kind of Business	/Industry
212	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give life. I	kind of work done OO NOT use retired	during most of d)	f working			
7	e filed within al Hygiene. i other than ' vant, the Me	Completed	12		Home	maker				wn Home	
n	be filed within 72 hours after death with the Marylan Ital Hygliene. Id other than "natural", or Itams 23a or 28a-1 show avant, I'ra Medical Examiner nast be notified at	Be (17. Father's Name (First, Middle, Last)					Name (First, A			
<u>X</u>	should I and Meni s marke umatic	은	Francis Joseph Ard					Veronio			
Maryland 21215-0036	O 00 00		19a. Informant's Name/Relationship (Ty			ng Address (Street					24
	of Health Itam 27 i		Robert O'Neil - N			Stone Av sition (Name of	venue,	Waldor		yland 20 Location - City of	
פֿר	Pages nent of h int: If its iry or o		1 Burial 2 □ Cremation 3 □ R	Removal from State	emetery, crer	natory or other place	,				
Baltimore,	artmel artant artant injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligense 			1S Cemete: Name and Addre		/1/2005			n, Maryland
g	permit. Pages Department of Important: If it any injury or o		V // hair the	MO13!							ryland 20781
			23a. Part1. Enter the disease, or compli	ications that caused the deatl							Approximate Interval Between
	Physician		shock, or heart failure. List only or Immediate Cause (Final	ie cause on each line.	· Az	WHA	DON				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	uence of):	110, ma	11010				DAK
	Examiner		Sequentially list conditions,	2.							
	D #	iner	if any, leading to immediate cause. Enter Unicertying Cause (Disease or injury	Due to (or as a consequent	uence of):						
	and and I-trans	Examine	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit										
287	ficate phys s the	edical		J							
Box	leath certific attending p I for use as	M/W	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna						23d. Date of de	alivery
	death e atte	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Feta 4 Pregnant at time of d]Ectopic pregnancy] Other (specify)	/			Month	Day Year
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	The law requires that the te has been signed by the bage 2 should be detache	by	Part II. Other significant conditions cor	stributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e			to the cause of death?
ord	w require been sig should b	ted						-	1 Tes	2194110 31.11	robably 4 Unknown
Records,	e 2 st	Completed						24a	. Was an autopsy performed:	prior to	utopsy findings available completion of cause of
_								10	Yes 21		s 2 No
Vital	ysician iis certif director	Be	25. Was case referred to medical examiner?	Hospital:		t 3 Don Oth	or	Death (Check			
ō	Phys rthis ral di	: To	1 Yes 2 No	28a. D te of Injury	ER/Outpatier 28b. Time of	IL 3D DOA	4 Nulsi			6 ☐Other (Specially occurred	ecity)
O	th. : After s funer	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2∐No				
Division of	I or Attand after death Diractor: /	ifice	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, str	eet, factory, office		28f. Loca	tion (Street or Town, St	and Number or F	Rural Route Number,
ā	s afte	Certification;	4 [] Notticide	building, etc. (Specify	y)			City	or rown, sie	110)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certifical completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the tir vestigation, in my o	ne, date and p pinion, death	place, and due occurred at the	to the cause time, date a	(s) and manner a and place, and du	is stated. le to the cause(s)
	To the within To the complex c	Me	29b. Signature and title of certifier	C N		29c. Licens	e number		ł	Date signed (Mor	
			1x mist	(Asco)		D	36601		n	1 ARCH 3	17,2005
2	(6)		30. Name and address of person who co			Print)	L.	P- 1		20912	
			DAVID W. BR	Da sistemala Ciana	turo		our	rark, a	us:	112	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 3 1 2005	2. Registrar's Signa	Lo	w					

				artment of Health and Mental rtificate of Death	Hygiene 005 12751	
	Dhoolai		Decedent's Name (First, Middle, Last)	2. Date Mont	of Death 3. Time of Death	
	Physicia /Medic		Ava Lee Allen	Marc	ch 26, 2005 1:00 P. M	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
			Solomons Nursing Center	Solomons	Calvert	
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date (Months Days Hours Min.	th, Day, Year) Country)	
	Director		579-22-3455	May	8, 1917 North Carolina	
	land ow		10a. State 10b. County 10c. City, Town or Le	ocation	10d. Inside City Limits	
	Mary -f sh	to	Maryland Calvert St. Leona	ard	1 ☐ Yes 2 ☐ No	
	r 28e	rec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	_
	h with	Funeral Directo	5445 Solomons Island Road	20685	United States	
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	or No- 14. Race - American Indian, c.) Black, White, etc.	_
ထွ	after or Ite		1 □ Never Married 2 □ Married 1 □ Yes 2 🔯 No	1 ☐ Yes 2 No Specify:	Specific	
S	urel',	d by	3X Widowed 4 □ Divorced Year or Dates:		wnite	_
<u>V</u>	"net	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry	
12	withir ane. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+) House	·	Homemaker	
2 2	filed within 72 hours after death with the Maryland Hygione. Ither than "neturel", or Items 23e or 28e-f show ant, Ite Medical Examera must be multiled at	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, N		
Maryland 21215-0036	d tal	To Be	Meridith Justus Carines	Ferry Belle 1		
<u></u>	2 should and Men is marke eumetic	Ě		ng Address (Street and Number or Rural Route N		
	and 2 salth a n 27 is		Barbara Landes (Daughter) 5445	Solomons Island Rd., S	St. Leonard, MD 20685	
altimore,	- I 9 =		20a. Method of Disposition 20b. Place of Disposition cametery cre	osition (Name of Date matory or other place)	20c. Location - City or Town, State	
Ë			TYPE Burial 2 Cremation 3 Memoval from State	oln Cemetery 3/31/05	Brentwood, Maryland	
a	permit. Pag Department Importent: I any injury o				Funeral Home, P.A. 4405	ī
<u> </u>	8 9 E E 8		3t 5 5 tt M00542 Bi	roomes Island Rd., Port	t Republic, MD 20676	3
г			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		Interval Between	
	Physician		Immediate Cause (Final disease or condition Cononary	arley disa	are Onset and Death—3 minut	っ
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	<u>(</u>		
	LAammer		Sequentially list conditions, in any, leading to immediate b. Due to (or as a consequence of).			
	ed nsit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause, (Disease or injury			
	be executed sicien and burial-transit	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	ate be executed hysicien and the burial-transit	dical E	d		Ţ	
89	g phys as the	ledic	<u> </u>			
ŏ	death certifica attending ph for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery	п
<u> </u>	deat	sicia	in the past 12 months? 1 □ Yes 2 → No 4 □ Pregnant at time of death 5 [Other (specify)	Month Day Year	
O.	at the I by the etach	Phy	9 🗆 Onknown			_
Ś	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as I	by	Part II. Other significant conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions.	inderlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
orc	w require been si should l	sted	3 - 60 - 20 - 5	0000		
Sec.	elaw has b	Completed	Congesto Factor		Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?	
<u> </u>	cate		V	10		
<u> </u>	nysicien: The la nis certificate ha I director, page 2	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check		-
of	Phys r this ral di	- To	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of	nt 3 DOA 47 Yoursing Home 5	Residence 6 Other (Specify)	-
O	ttending Phy death. stor: After this the funeral o	tion	1 atural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		1
Division of Vital Records,	I or Attending Physicien: after death. Director: After this certifice in by the funeral director, i	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st		tion (Street and Number or Rural Route Number,	
6	s afte	Certification:	4 Homicide determined building, etc. (Specify)	City	or Town, State)	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, and due to	to the cause(s) and manner as stated.	
	To the Ho within 24 To the Fu completel	edical	one) and manner stated.	ivestigation, in my opinion, death occurred at the		
	To To	Σ	29b. Signature and title of certifier MD	29c. License number	29d. Date signed (Month, Day, Year)	
			Allending Thisi-	V 1177	21,21,	Ц
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, ストレルト M U N S M 1 M . カー 110 ラビ	Print) RD. Prince Fred	lovek MD 20678	
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature			-
	Registr		MAR 3 1 2005 Men. 15 Souls			

		1 - For State Registrar		ryland / Dep <i>Ce</i>	rtificate o			Reg. No.	0 16/06
Physic	ian	Decedent's Name (First, Middle, Las	•				2. Date of De. Month	ath Day	3. Time of Death
/Med	ical	James Henry					4	4	2005 10:10 a
Exami	ner	4a. Facility Name (If not institution, give Bayside Care Ce				n, or Location of Dea		4c. County	
_		5. Social Security Number 6. Se		(In yrs. last birthday)	+	ngton Parl		St. M	
Funeral Director			M 2□F	58 Yrs.	Months Da		n. (Month, Da	y, Year)	Birthplace (State or Fore Country)
		Usual Residence of Decedent		_30			12-13-1	946	Maryland
how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lim
Ba-f g	cto	MD St. Mar	y's	Leonard	town				1 _₹ Yes 2□
be filed within 72 hours after death with the Maryland tital Hygliene. Id other than "natural", or itams 23a or 28a-1 show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of \	What Country?
ath w	ra	22815 Duke Stree				20650			States
er de Itams	une	11. Marital Status	12. Was Decedent E- Amed Forces?		Was Decedent of If Yes, specify C	of Hispanic Origin? (Juban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.
s aft	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give	1964-	1 ☐ Yes 2 🙀 I			Specify	
tural tural	edt	15. Decedent's Ed	Year or Dates:	1974	dent's Usual Oc	augation	1		Diack
in 72 n" na	piet	(Specify only highest grad	de completed)	(Give	kind of work do DO NOT use rei	cupation ne during most of wi tired)	orking	160. Kind of Bi	usiness/Industry
d within jiene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	ck Drive			Тиопоп	
e filed I Hygie other	a	17. Father's Name (First, Middle, Last)			on Direc		ime (First, Middle,		ortation ne)
should be nd Mental markad o	To B	Joseph Bolt				Edna T	onev		
d 2 should th and Men 7 is marka traumatic	-	19a. Informant's Name/Relationship (T		19b. Maili	ng Address (Stre	eet and Number or F		er, City or Town,	State, Zip Code)
C = O -		Tanya Beamon/ Wife	e	P.0). Box 3	46, Leona	rdtown,	Marylano	1 20650
itar itar		20a. Method of Disposition	Demonal form State	20b. Place of Dispo	osition (Name of matory or other)	olace)	Date	20c. Location -	City or Town, State
Pages nent of I ant: if its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify,		Brinsfiel		,	-05	Charlott	e Hall, MD
permit. Page Department of Important: If any injury or once.		21. Signature Juner Juner Licens	see /					l Funera	1 Home, P.A.
82 5 5 8		Edward N. Brinsfie	eld, Uf. M	100052 2	2955 Ho	llywood R	oad, Leor	nardtown	, MD 20650
death certificate be executed e attending physician and d for use as the burial fransit	icai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of): consequence of):	x will	Fulm	inay 10	llarta	ns
I the death certific by the attending p ached for use as	Physician/Medi	in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death 3 me of death 5	Ectopic pregna			Mor	
luires that r signed b	d by	Part II. Other significant conditions co	ntributing to death but	not resulting in the ui	nderlying cause	given in Part I.			ibute to the cause of death? 3 Probably 4 Striknov
w require been signature should b	lete						24a. Was a	24h V	Vere autopsy findings availat
ate hi	Completed						autops	sy p med? d	rior to completion of cause of eath?
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only or	ne)	
Attending Physician: ar death. actor: After this certifics by the funeral director.	2	1 Yes 2 100	1 L Inpatient		1 3LI DOA	7	Home 5 Reside		
After	Į.	Pending 5 Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	V	lork?	28d. Describe ho	ow injury occurre	ed
e att	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)		☐ Yes 2 ☐ No	28f. Location (Si City or Town	treet and Numbe n, State)	er or Rural Route Number,
	ŏ	29a. Certifier Certifying Phy	sician: To the best of	my knowledge, death	occurred at the	time, date and place	e, and due to the co	ause(s) and mar	nner as stated.
		[Check only 2] Madical Evami	and manner state	id.	restigation, in the		orred at the time, d	ate and place, a	nd due to the cause(s)
nospital or 4 hours afte Funaral Dir ely filled in I	edicai	one) 2 Medical Exami							
Io the Hospital of Atte within 24 hours after de To the Funaral Diract completely filled in by th		Medical Exami	1			nse number	2	9d. Date signed	(Month, Day, Year)
nospital or 4 hours afte Funaral Dir ely filled in I	edicai	one) 2 Medical Exami	6			/99/7	2	9d. Date signed	(Month, Day, Year)
nospital or 4 hours afte Funaral Dir ely filled in I	edicai	one) 2 Medical Exami	leted cause dea		Print)	19917		4/4/0	5

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			For State	State of Marylan				d Mental H	ygiene	2 (2 (***	يرفنى والمواق والرباء بالأن و
`*			1 - State Registrar	-41	Centi	ficate of	Death	2. Date of	Reg. No:	Щ5_	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, La.					Month	Day	Yeer	11:56 PM
	/Medic		4a. Facility Name (If not institution, give	e street and number)	4	4b. City, Town, o	or Location of D		4c. Co.	unty of Death	11.50
	Examin	er	1 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	arulard Medic		r Bal	ti mae	city			
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of ! Min. (Month,	Birth Dav_Year)	9. Birthp	lace (State or Foreign
	Director		228-80-3615	X M 2□ F 5	1 Yrs.	World S Days	Tiodis	July	12, 19	53 _V	
	and		Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	tion				1:	0d. Inside City Limits
	Maryl -f sho	tor	Md. P.G.	7	Temple	Hill's					1⊠Yes 2□No
	r 28a	Directo	10e. Street and Number		CIUPIC	10f. Zip Code			10g. Citizen	of What Coun	itry?
	th with	al D	P.O. Box 274			207	757		Unit	ed St	ates
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Wa	as Decedent of H es, specify Cubi	lispanic Origin an, Mexican, F	? (Specify Yes or Puerto Rican, etc.)		Race - Americ Black, White,	an Indian,
30	s afte	by F _L	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1 🗆	Yes 2X No	Specify:		Spe	ecify:	ale.
215-0036	s within 72 hours after death with the Maryland lien. Than "natural", or items 23a or 28a-f show the Madeal Examinational beneditied at		15. Decedent's Ed	L	16a. Deceder	nt's Usual Occup	pation		16b, Kind o	Bla	
ر 15	nin 72 In "na Wedik	Completed	(Specify only highest gra		(Give kir life. DC	nd of work done NOT use retire	during most of d)				,
717	giene.	Som	Elementary/Secondary (0-12)	3	Emplo	yment	Speci	alist	JHP	Inc.	
and	be filed ntal Hygi of other event,	Be	17. Father's Name (First, Middle, Last)					Name (First, Midd		name)	
5		ဥ	Kenneth L. Bro				1	ie B. W			
Mar	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	î 15	19a. Informant's Name/Relationship (or Rural Route Nun	nber, City or To	wn, State, Zip	Code)
	1 and Health em 27 ther ti		Rosalie Brooks 20a. Method of Disposition	20b. F	Place of Disposit	Box 27 e Hill ion (Name of		. 20757 Date	20c. Location	on - City or To	wn, State
saitimore,	0 0 = 5		1 Burial 2 Cremation 3 '4 Donation 5 Other (Specif		cemetery, crema			4/2/05		-	
			21. Signature of Funeral Service Licer			Name and Addre		Hodges			-17
ñ	permit. Departr Imports any Inji		Marico &	dward	1/391	0 Silv	er Hi	11 Rd.,			
	2016		23a. Part1. Enter the disease, or com- nock, or heart failure. List only	plications that caused the deat	h. Do not enter	the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ACINE	nue	loger	2005	(Red	enic	1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	juence of)		* *				
	CXAIIIIIlei	_	Sequentially list conditions,	b. Due to (or a a conseq	JS - TT	027	Dise	use			
	pe jist	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	dence or).					- 0	
	al-train	xar	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):						
8/PU	cate be executed physician and the burial-transit	dical E	(d							
Q	tificat og phy as th	led	T								
X P Q	es that the death certific gned by the attending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		ctopic pregnanc	у		23d.	Date of delive	ry Dav Year
d	e dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		other (specify)				MOTH	Day real
J.	requires that the een signed by th hould be detache	Phy	9 ☐ Unknown Part II. Other significant conditions of	antributing to death but not rec	ulting in the und	orbino causo on	en in Part I	23a Di	tobacco use o	contribute to th	e cause of death?
က်	ires ti signe 1 be c	by	ratti. Other significant conditions of	ominating to death but not res	atting in the disci	onying cause gn	rairiiri ditti.		Yes 2□N		
cord	~ Q 75	Completed						24a. W	1s an 24	th Were auto	psy findings available
ě	e ta has	mpi						— au	topsy rformed?	prior to cor death?	npletion of cause of
Vital	iiclan: Th certificate rector, pag	e Co	25. Was case referred to medical				26 Place of	1 ☐ Yes		1 🗌 Yes	2 No
>	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2	ER/Outpatient	3□ DOA Ott	ner-	ng Home 5 ☐ Re		Other (Specify	")
	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui	ry at	28d. Describ	e how injury oc	curred	
_		0	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	,,		Yes 2 □ No				
×	endin sath. or: Aft	atl	E L / tooldont	One Olege of Injury At h	ome, farm, stree	t factory office			(Street and Nu own, State)	ımber or Rura	I Route Number
INISIO	or Attending Fiter death. Her death. Hector: After on by the funera	rtificati	3 Suicide 6 Could not b	building, etc. (Specif	(y)	i, labiory; omico		Ony or .			rriodia ramber,
=	or A	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Specif			mo dete'			manner and an	
=	spital or A		3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Exer	building, etc. (Specifican: To the best of my known inner: On the basis of examinations)	owledge, death o	occurred at the til		place, and due to the	e cause(s) and		ated.
=	spital or A	Medical Certificat	3 Suicide 4 Homicide 6 Could not b determined	building, etc. (Specification) ysician: To the best of my kno	owledge, death o	occurred at the til	opinion, death	place, and due to the	e cause(s) and e, date and pla		ated. the cause(s)
=	the Hospital or Ai nin 24 hours after of the Funeral Direct npletely filled in by		3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) Check only one)	building, etc. (Specifican: To the best of my known inner: On the basis of examinations)	owledge, death o	occurred at the til stigation, in my c	opinion, death	place, and due to the	e cause(s) and e, date and pla	ce, and due to	ated. the cause(s)
=	spital or A		3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) Check only one)	building, etc. (Specifican: To the best of my known inter: On the basis of examinating and manner stated.	owledge, death o	eccurred at the tile stigation, in my control 29c. Licens	ppinion, death	olace, and due to the time	e cause(s) and e, date and place 29d. Date sign	gned (Month,	ated. the cause(s)
=	spital or A		3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Specifican: To the best of my known inter: On the basis of examinating and manner stated.	owledge, death o lition and/or investigation on 23a) (Type, Pri	eccurred at the tile stigation, in my control 29c. Licens	ppinion, death	place, and due to the	e cause(s) and e, date and place 29d. Date sign	gned (Month,	ated. the cause(s)

			1- For State Registrar	ate of Maryland / Depart	artment of Health and Martificate of Death	•	2 005	12754
I	Physic /Medi		1. Decedent's Name (First, Middle, Last) Mary Reynolds Brown			2. Date of Death Month March 29.	Day Year	3. Time of Death 16:05 PM
	Examir		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death	Moreon 27,	4c. County of Death	10.03
Н			913 Biddle Street 5. Social Security Number 6. Sex	7 Acc (In use lock high to .)	Chesapeake City		Cecil	
	Funeral Director		217-24-5950 1 M 2	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye January 1	9. Birthp Coun 0,1927	place (State or Foreign htry) MD
	ryland how		10a. State 10b. County	10c. City, Town or Lo	cation		1	0d. Inside City Limits
	Be-1 s	cto	MD Cecil	Chesape	eake City			1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	itry?
	has 23	era	913 Biddle Street 11. Marital Status 12. W	as Decedent Ever in U.S. 13.1	21915	ocify Ves or No-	USA 14. Race - Americ	an Indian
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumetic event, If a Medical Examinar must be invitibled at once.	Completed by Funeral Director	1 Never Married 2 Married 1	med Forces? □Yes 2XNo	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White,	
2-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/Inc	lustry
12	within the han	mpl	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	kind of work done during most of working NOT use retired)			
2	filed v Hygie other t	ပ္ပ	1 2 17. Father's Name (First, Middle, Last)	In.	structional Assist	ant (First, Middle, Maid	Public Sch	iools
an	lid be lental ked o ic eve	To Be	Harold R. Reynolds		Marion		en sumame)	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Pr.	int) 19b. Mailir	g Address (Street and Number or Rura		y or Town, State, Zip	Code)
, Z	and 2 ealth m 27 I		Russanne B. Foster/1		Knights Corner Ro	ad, Elkto	n, MD 219	21
ore	ges 1 t of H If itel		20a. Method of Disposition 1	allirom State	natory or other place)		Location - City or To	
Ē	it. Pa irtmen irtent: njury		' 4 □ Donation 5 □ Other (Specify)	Bethel Ce	metery 04-0	2-2005 Ch	esapeake C	ity, MD
Ba	perm Depa Impo any i		21. Signature of Funeral Service License	22	Name and Address of Facility R.T	. Foard Fi	uneral Hom	e, P.A.
			23a. Part1. Enter the disease or complication shock or heart failure. List only one caus	s that caused the death. Do not enter	8 George Street, of the mode of dying, such as cardiac of	r respiratory arrest,	e city, Mu	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Glioblastona (M	_			Interval Between Onset and Death
	Examiner		Sequentially list conditions, b					
	pa jis	Examiner		Due to (or as a consequence of):				
	and and II-tran	хаш	that initiated events c.	Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transit	cai E						
õ	tificate ig phy as the		0.					
Вох	death certificate be executed e attending physician and id for use as the burial-transit	an/M	200. Was decedent pregnant	es, outcome of pregnancy	Ectopic pregnancy		23d. Date of deliver	у
	he dea the at	Physician/Med	1 Vos 2 Flato		Other (specify)		Month t	Day Year
о. О	law requires that the de as been signed by the 2 2 should be detached	y Ph	Part II. Other significant conditions contribution	ng to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	a cause of death?
Vital Hecords,	w requires been sign should be	ed by					2 (10 3 (1) Proba	
ပ္က	aw re	Completed				24a. Was an	24b. Were autop	sy findings available
Ĭ	The ate h	E O				autopsy performed: 1 Yes 2	death?	pletion of cause of
<u> </u>	cian: ertific ector,	Be (25. Was case referred to medical examiner?		26. Place of Death		10 100	
6	Phy this	2	1 ☐ Yes 2 ☐ No Hospital 27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpatient			6 ☐Other (Specify)	
ב	une utte	tion;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at	8d. Describe how in	lury occurred	
DIVISION	Atter ar dea ector by the	ertificati	3 Could not be	. Place of Injury - At home, farm, stre		8f. Location (Street	and Number or Rural	Route Number,
5	tal or rs afte al Dir	Cert	4 Homicide	building, etc. (Specify)		City or Town, Sta	ite)	
	n 24 hou n 24 hou he Funer pletely fill	edical	Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or invidended in the control of	occurred at the time, date and place, as estigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as sta nd place, and due to t	ted. the cause(s)
	To To Com	Σ	29b. Signature and title of certifier		29c. License number	29d. C	ate signed (Month, D	ay, Year)
			1/ fullio Hos	end mil	D35653	3	131/05	
	8		30. Name and address of person who complete	d cause of death (Item 23a) (Type, F	Print)	UD 010	01	
	Stat	e	Martha Hosford, MD 31. Date filed (Month, Day, Year)	Registrar's Signature	tSt. 104, Elkton	, MD 219	2.1	
	Registra	_	APR 1.2005	Claren St Agold				

ADH JOSEPH ISAAC BUCKLER, 3rd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Health and Mental Hygiene 1 State of Maryland / Department of Death and Mental Hygiene 1 State of Maryland / Department of Death and Mental Hygiene 1 State of Death Registrar Reg. No. 05-2294 Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 Year **Physician** Day APRTL 0705 Joseph Buckler III Isaac /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5598 WEST CARVEL DRIVE CHURCHTON ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Birthplace (State or Foreign Country) Months 1**X** M 2□ F Director Yrs Jan 15, 218-92-8878 26 1979 Maryland Usual Residence of Decedent the Maryland or 28e-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 호 MD Anne Arundel Churchton 1 ☐ Yes 2 X No by Funeral Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 23a or 5598 West Carvel Drive 20733 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r then "naturel", or Items The World Examiner in 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 diesel mechanic heavy equipment other 17. Father's Name (First, Middle, Last) ... Pages 1 and 2 should be fill thent of Health and Mental Hytent: If item 27 is marked out 18. Mother's Name (First, Middle, Maiden Sumame) Be Buckler, ၉ Joseph Isaac Jr. Cheryl Howes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t 5705 Blaine Rd., Churchton, MD Cheryl Howes, mother 20733 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 permit. Page Department o Importent: If eny injury or once. Woodfield Cemetery 04-07-2005 Galesville, MD Lice Lice 22. Name and Address of Facility selocel Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Fentanyl and Phencyclidine Intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 2 1 XYes 2 No Pound Pay Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter unk 1 Natural 5 Pending Found death. investigation 1 ☐ Yes 2 🛣 No 2 Accident after death Director: 28e. Place of Injury - At home, arm, street, factory, office bround at home 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State 5598 W.Carvel Dr. Churchton, Md 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hospital or Attending Physicien: within 24 hours a To the Funerel L

State

(Check only one)

29b. Signature and title of certified

Mogracos

31. Date filed (Month, Day, Year)

Te

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 1 2005

KOREU

32. Registra s Signature

DHMH 17 Rev 1/2001

W

29c. License number

OCME

111 Penn Street

29d. Date signed (Month, Day, Year)

APRIL 2, 2005

Baltimore, Maryland 21201

			For Stete Registrar	State of Marylan		artment of		-	giene Reg. No 2005	12755
			Decedent's Name (First, Middle, Last))				2. Date of De.	ath	3. Time of Death
	Physicia /Medic		Richard Norma					March		
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,			4c. County of Dea	
	Funeral		Calvert Memor 5. Social Security Number 6. Se			Prince	If Under 24	Hrs. 8 Date of Birt	Calv	thplace (State or Foreign
	Director		170-34-2414	^{0 M 2□F} 61	Yrs.	Months Days	Hours	Min. (Month, Da 6/19/	1943	PA
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	jor	MD Calv			hesape	ako Bo	ach		1X Yes 2 □ No
	n the	Director	10e. Street and Number	,610		10f. Zip Code	INC DC		10g. Citizen of What C	ountry?
	23a c		6324 North 3r	d Street			207		USA	
	er des	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of f Yes, specify Cub	Hispanic Origi pan, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Black, Whi	
336	urs aft	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1		1□Yes 2XINo	Specify:		Specify:	White
5-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23e or 28e-f show umatic event. If a Modical Examination at the multiple at	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occu	pation during most of	of working	16b. Kind of Business	/Industry
2	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire		i	Disabaia	Q
מ	filed v Hygie ther t	e Co	17. Father's Name (First, Middle, Last)	2	Pr	oject E		s Name (First, Middle,	Electric Maiden Surmame)	Company
an	ould be filed v Mental Hygie terked other i	To B	Richard Brin1	ey			Bei	rtha Wand	lricke	
Maryland 2121	s 1 and 2 should if Health and Men item 27 Is marke other traumatic.		19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Stree			er, City or Town, State.	Zip Code)
	and in 27 m 27 her tr		Todd Brinley/So		_	North H sition (Name of	ighla	nd Ave.,	E.Syracus	
altimore,			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	cemetery, crer	natory or other pla			20c. Location - City or Beltsvill	
			*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lines			ake Cre			Wood F.H	
B	permit. Departr Imports any Inji		16.W0	w				unkirk, M	ID 20754	., P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the deat ne cause on each line. a	re h	eart fa lation	ing, such as ca	ardiac or respiratory as	rest,	Approximate Interval Between Onset and Death Year s
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	juence of):	4/escli	7			Several months
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	d. Stage 4	puence of):	hoyeal	can	er with	liver metastexus	Several munths Several munich
P.O. Box 6	The law requires that the death certificate be executed attending physician and attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ıldeath 3∟	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year
	quires that n signed t	by	Part II. Other significant conditions co	ntributing to death but not res		nderlying cause g	iven in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
Records,	alcian: The law require certificate has been si irector, page 2 should t	Completed	Sleep aprea					24a. Was autop perfo	prior to death?	utopsy findings available completion of cause of
Vital	yalcian: is certifica director, I	BeC	25. Was case referred to medical examiner?					f Death (Check only o	ne)	
Division of \	Jing Phy n. After this funeral d	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Anpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju		28d. Describe h	dence 6 □Other (Spenow injury occurred	ecify)
Divis	tal or Attencts attended the strength of the s	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of		eet, factory, office		28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical Exami	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deatl ation and/or in	vestigation, in my	opinion, death	occurred at the time,	date and place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				ise number		29d. Date signed (Moni	
1			30. Name and a gress of person who co	HOSPITALIST	n 22a) /Tuna		0390		3/31/0	7)
	5		ADEED JABER	3	PITT	1	PRINC	e FREDER	ICE MO	20678
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa)	, ,,,		, , ,	
	Registr	ar	APR 0 1 2005	Page His	Lagara B					

		State of Maryland / Dep	artment of Health and Nertificate of Death		iene 2005	12757
		Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
Physicia /Medic		Michelle Denise Baldwin		March 2	5, 2005 Year	1:50 A. M
Examin	er	ta. Facility Name (<i>If not institution, give</i> street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederick		4c. County of Deat Calvert	h
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	9 Birt	hplace (State or Foreign
Funeral Director		215–74–2417 1 M 2 F 38 Yrs.	Months Days Hours Min.	June 2,	Year) Co	yland
pu 🛦		Usual Residence of Decedent 10c. City, Town or L 10a, State 10b, County 10c, City, Town or L	ocation			10d. Inside City Limits
Maryla f sho	jo	Maryland Calvert Prince Fr				1 ☐ Yes 2 ☐ No
28a-	rect	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Co	
h with	a D	1675 Mallard Point Road	20678	τ	United Sta	tes
ams 2	Funeral Director	Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. And Health and Mental Hygiene. Or other traumatic event, the Medical Examinational be notified at	by F.	1 □ Never Married 2 Ă Married 1 □ Yes Ă No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: Wh:	ite
2 hour	ted t	15. Decedent's Education 16a. Dece	edent's Usual Occupation		16b. Kind of Business/	
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ad oti) Be	17. Father's Name (First, Middle, Last) Hugh Hall	Phyllis		naideir Sumame)	
should and Me mark imatic	ဥ		ling Address (Street and Number or Rui		City or Town, State, 2	Zip Code)
and 2 seath ar and 27 is na 27 is nar trau		Graham Martin Baldwin (Husband) 1675	Mallard Point Rd.	., Prince	e Frederic	k, MD 20678
as 1 a of Hear litam		20a. Method of Disposition 20b. Place of Disposition 1 □ Burial 2 🗓 Cremation 3 □ Removal from State	osition (Name of ematory or other place)	Date 2	20c. Location - City or	Town, State
Pages ment of thant of thant: If its ury or of		'4 □Donation 5 □Other (Specify) Metropol	itan Crematory 3/2		Alexandria,	
permit Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If itam 27 is marked other than any injury or other traumetic event, the Meane.			22. Name and Address of Facility Rateroomes Isl. Rd., I			
		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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/Medical Examiner		resulting in death) Due to (or as a consequence of):	,			
	e	Sequentially list conditions, b. Due to for as a consequence oi):	exeast camer			years.
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se as	0	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivon
leath c	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
t the d	hysi	9 Unknown				
gned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to	the cause of death?
requir een si				100		
ne law has b ge 2 st	Completed		· · · · · · · · · · · · · · · · · · ·	24a. Was a autops perforn	ned? death?	topsy findings available completion of cause of
in: The interpretate or, par		25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 th (Check only on	1 ☐ Yes	2 4 No
ysicia ysicia s cert	o Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Impatient 2 ☐ ER/Outpatie	Othor		ince 6 Other (Spe	cify)
ng Ph Ifter thi	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year)	Work?	28d. Describe ho	w injury occurred	
tandii leath. for: A the fu	catic	2 Accident investigation	M 1 Tes 2 No	OPf Logation /Ct	reet and Number or Ri	ural Bouto Number
lor At after of Diraci	Certification:	4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	City or Town	, State)	irai noute Number,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funarial Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1	ath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
o tha vithin ? o the	Med	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Mont	h, Day, Year)
r->= 0		My mo, HOSPITALIST	060390		3/25/0	5
15		30. Name and address of person who completed cause of death (Item 23a) (Type ADEAB A JABER 100 H056	Print) PRINTER RO. PRIN	uce fr	EDELICK,	mp 20678
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	· · · · · · · · · · · · · · · · · · ·			
Registr	rar	MAR 3 1 2005 Beauty M. Soule				

Please Type or Print in Black Indelible Ink, Assure All Copies Are Legible. Sinend item 26 per me 9842 4-13-05 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Year 2005 Farid Cyrus Bina, M.D. April Unknown 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 7422 Damascus Road Gaithersburg Montgomery If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1**X**]M 2□ F Yrs March 6, 1961 505-02-8347 Iran Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√XNo Gaithersburg /aryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7422 Damascus Road 20882 Iran 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Neurologist Private Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Karamali Bina Fatemah Rasekh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Syed Bina - Brother 7422 Damascus Road, Gaithersburg, MD 20882 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aprain 1XXBurial 2 □ Cremation 3 □ Removal from State 2005 4 ☐ Donation 5 ☐ Other (Specify) Stonewall Memory Gardens Manassas, Virginia 22. Name and Address of Facility Loudoun Funeral Chapel, Inc. 21. Signature of Funeral Service Licensee 158 Catoctin Circle, SE, Leesburg, VA 20175 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dunshot Wound Due to (or as a consequence of): eore SSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 21800 1 TYes 20 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Hesidence 6 | Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) Injury 1 Netural 5 Pending investigation 11 5,2005 1 Yes t-Intilcted Unknowy 2 Accident 6 Could not be determined 28- Place of Injury - At home, farm, street, factory, office building, etc. (Spenify) 3 Suicide 4 ☐ Homicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 7422 Dawnscus Ray, Lity tons ville, MD Kyara 10me 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

ille Pike, G-100, Rockville, 110 2085

Physician /Medical Examiner The law requires that the death certificate be executed bunal-transit Division of Vital Records, P.O. Box 68760, attending physician for use es the buria been signed by the a should be detached f cate has t certificate or Attending Physician: funeral director, After this death. after deat Director: 24 hours a Hospital the

Physician

Examiner

Funeral

Director

of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 is marked oths any Injury or other traumatic event.

the Maryland

With W

death

altimore, Maryland 21215-0020

/Medical

Funeral Director

ģ

Completed

Be

Examiner

Physician/Medicai

Completed by

Be

29a. Certifier (Check only one)

29b. Signature and title of certifier

ricia

31. Date filed (Month, Day, Year)

Certification: To completely filled in by edicai within 2 0

State Registrar

omsk

30, Name and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature Bleen & Sperke

May, 118

DHMH 16 Rev 6/95

		_	For State	State o	f Mary	•	artment <i>rtificate</i>			Mental Hygi		15	127	159
			Registrer 1. Decedent's Name (First, Middle, Las	r)	_		incare	0, 0	Catri	2. Date of Death	g. No."		3. Time of	Death
	Physicia	an			٦1 م R	lackburn				April		005	1112	Ам
	/Medic		4a, Facility Name (If not institution, give			Lackbarn	4h City T	own or l	ocation of Death		4c. County		1	*
	Examin	er		31/001 2010 110	iii,		, ,	ton	odanon or boan		Cec			
			215 Locust Lane 5. Social Security Number 6. Se	ix I	7. Age (In	yrs. last birthday)	If Under 1		If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State o	or Foreign
	Funeral Director			⊒м 2[X F	61	Yrs.	Months	Days	Hours Min.	OCT 30,	1943	Mar	vland	,
			Usual Residence of Decedent											
	how		10a. State 10b. County		10	c. City, Town or Lo	cation					1	0d. Inside C	
	e Ma	cto	Maryland Cecil			E1kton							1 XYes	2 140
	를 26 를 다	Directo	10e. Street and Number				10f. Zip 0			10	g. Citizen of \			
	ath w		215 Locust Lane				1	921			Unite			
	er de	Funeral	11. Marital Status	12. Was Dec	orces?	r in U.S. 13.	Was Decede If Yes, specif	ent of His fy Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No- o Rican, etc.)		ck, White,	an Indian, etc.	
30	', or l	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes If Yes, Gi Year or D	ve		1 ☐ Yes 2	X No	Specify:		Specify	y: Wh:	ite	
3	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show do other than "natural" or items 23a or 28a-f show event, I'm Medical Evaninar must be notified at	edt	15. Decedent's Ed			16a. Dece	dent's Usual	Occupat	ion	1	6b. Kind of B			
1215-0036	In 72	Completed	(Specify only highest gra-	de completed)	1.4== 5.\	(Give	kind of work DO NOT use	done du retired)	iring most of wor		6b. Kind of B Fabric			aper
25	iene.	mo	Elementary/Secondary (0-12)	College (1-401 5+)	Custom	er Serv	ice R	epresenta	tive	Manufa	ctur	ing	
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<u>a</u>	Aenta Aenta rked ric ev	To B	Alton B. Carpente:	r					Celestia	al Louise	Harris	3		
Maryland 2	and N s ma		19a. Informant's Name/Relationship (7	ype, Print)						ıral Route Number,				
	and 2 salth n 27 i		Deanna L. Price/	Daughte					each Roa	d, Earlev				1919
<u>S</u>	iges 1 and 2 should be fi it of Health and Mental H : if Item 27 is marked of or other treumatic ever		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from		ob. Place of Dispo cemetery, cre Gilpin M	sition (Name matory or oth	e of her place	Apri	17,	loc. Location	City or To	own, State	
Ĕ	Pages ment of ent: if it ury or o		'4 □Donation 5 □Other (Specify			Memorial	. Park		2005	5	E1kton			
Baltimore,	permit. Pag Department Importent: i any injury o once.		21. Signature of Funeral Service Licen	See .		H	2. Name and	Address OME	for Fun	erals, P. reet, Elk	Α.			
	20.5 2 3		Donuid &	· Hu	ks	10	03 W.	Stoc	kton St	<u>reet, Elk</u>	ton, M	ary1a		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that one cause on	caused the each line.	death. Do not en	ter the mode	of dying	, such as cardia	or respiratory arre	st,		Approximation Interval Bet Onset and	tween
3	Physician	0	Immediate Cause (Final disease or condition	a. 5.	idde	en cor	Tree	de	dh				•	
	/Medical Examiner		resulting in death)	Due to	(or as a co	onsequence of):								
Н		<u></u>	Sequentially list conditions,	b. Due to	(or as a co	onsequence of):		_				-		
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	L.		10.00								
	and and trar	хап	that initiated events resulting in death) Last	c. Due te	oras a co	onsequence of):	1						-	
8760	icate be executed physicien and s the burial-transit		l	1 Di	Obe	eles								
687	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edical		d										
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			7				23d. Da	ite of deliv	ery	
ň	death a atte d for	icia	in the past 12 months? 1 ☐ Yes 2 XNo	4∐Preg	nant at tim		⊒Ectopic pre ⊒ Other (spe				Mo	onth	Day	Year
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ïġ	aquire an sig	ed	Chronic oth	ral	fipe.	Matro	\			1 🗆 Ye	s 2 No	3 Prol	bably 4 🗌	Unknown
000	aw re is bea	piet	Serve mitr	al re	Epus	proton	j			24a. Was ar			psy findings impletion of o	
ŭ	The law	Completed	hlo Smoke	(\mathcal{I})				perform	red?	death?		
ta	len: rtifica stor, p	0	25. Was case referred to medical					,	26. Place of De	ath (Check only one	9)			
>	nysic nis ca direc	ToB	examiner? 1 Tes 2 No	Hospital: 1	Inpatient	2 ER/Outpatie	nt 3 DO	A Othe	r: 4 🗆 Nursing H	łome 5 🏋 Reside	nce 6 🗆 Oth	ner (Speci	(y)	
0	ng Pt fter tf neral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date (Mor	of Injury oth, Day Yo	28b. Time of Injury	of 28	Bc. Injury Work	at ?	28d. Describe ho	w injury occur	rred		
Sio	Attendideath. ctor: A y the fu	catio	2 Accident investigation				М		es 2 No					
Division of Vital Records,	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined	286. Plac	e of Injury ling, etc. (- At home, farm, st Specify)	reet, factory,	office		28f. Location (Sti City or Town		oer or Hur	ai Houte Nun	nber,
	urs a urs a erei D		CON CONTROL OF CONTROL OF	valaine. To th	- hast of m	w knowledge, desi	th occurred a	at the time	o data and place	e, and due to the ca	use/s) and m	20001 200	tated	
	Hos 24 ho Fun stely f	Medical	29a. Certifier (Check only 2 Medical Exen	niner: On the	pasis of ex	amination and/or in	vestigation,	in my op	inion, death occi	urred at the time, da	ate and place,	and due t	o the cause(s) .
	o the	Me	29b. Signature and title of certifier	2.10.111			29c.	License	number	29	d. Date signe	ed (Month,	Day, Year)	
	⊢s⊢ŏ			aus	•		D	00	06075	56	4/41	105		
			30. Name and address of person who	completed cau	se of deat									
	7		Orden C	hr.50	490	n, MD 2		st M	ain Stre	eet, Elkte	on, Mai	rylan	d 2192	21
	Sta		31. Date filed (Month, Day, Year).	2005 32.	egistrar's	Signatu		9						
	Regist	rar	HPK 14	.003	ROLL.	1 1								

			For State Registrar	State	of Maryla	ind / Depa <i>Cei</i>	artment of H	ealth and M Death		iene200	12760
			1. Decedent's Name (First, Middle,	Last)	-				2. Date of Death	n Day Year	3. Time of Death
	Physici: /Medic			Dorothy 1	M. Barf	ield			April	3 200	
	Examin		4a. Facility Name (If not institution,		•			Location of Death		4c. County of De	ath
			Laurelwood Ca	re Cente:	_	n la sa hilab de il	E1kton	If Under 24 Hrs.	0.0-1-10-1	Cecil	
	Funeral Director		5. Social Security Number 577-38-7157	6. Sex 1 □ M 2 🛣 F	7. Age (in yr	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 24,	1929 Dist	inthplace (State or Foreign Country) trict of Columbia
			Usual Residence of Decedent		175				Oury 24,	1727	crice of cordinate
	rylan	_	10a. State 10b. County		10c. (City, Town or Lo	ocation				10d. Inside City Limits
	Ba-1 s	cto		Castle_		Wilming					1 Yes 2 XNo
	with th	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What (
	eath v	Funerai	22 Iowa Road	12 Was Do	cedent Ever in	11 12	19808 Was Decedent of Hi	enania Origin? (Sn	acifu Vac or No	United S	
	iter d	Fun	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed F	Forces?	0.3.	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
3	urs a	by	3 XWidowed 4 ☐ Divorced	If Yes, G Year or	NIA6		1 ☐ Yes 2 📉 No	Specify:		Specify:	White
215-0036	72 ho	Completed	15. Decedent' (Specify only highest	s Education	()	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Busines	s/Industry
7	ithin na.	npie	Elementary/Secondary (0-12)	T	(1-4or 5+)		kind of work done of DO NOT use retired,)	1	T II O	***
2	iled w tygier her ti		12 17. Father's Name (First, Middle, L	actl		Но	memaker	10 Mother's Now		In Her Own	n Home
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiena. Is marked other than "netural", or Items 23a or 28a-1 show aumatic avant, It.e. M. dical Examination to the intilling at) Be	Harry Brommer	.431/				18. Mother's Name	et Maescl		
2	shoulk nd Me mark imatik	Ţ	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street a			City or Town, State.	Zip Code)
2	and 2 sealth arm 27 is		Donnie Wayne		/Son					aware 1980	
ē,	s 1 a		20a. Method of Disposition		20b		osition (Name of matory or other place			Oc. Location - City of	
Ē	Pages nent of I ant: If its ary or o		1 □ Burial 2 X Cremation 1 □ Donation 5 □ Other (Sp		ii State		is & Co. Inc	11-22-		Pennsylvai	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or othar traumatic as		21. Signature of Funeral Service L	icensee	à						land 21921
			23a. Part1. Enter the disease, or o	complications that	caused the de	ath. Do not ent	J3 W. Stoc ter the mode of dying	CKTON STR g, such as cardiac	eet, Llk or respiratory arre	ton, Mary	Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final	only one cause on	each line.	- 400	F . 1	1110			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	(of as a cons	equence of:	PG/10	sie_			4 days
	Examiner		Coguantially list conditions	L. Co	JPD						>5/11/11/5
7	φ ≔	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a cons	equence of):					7
•	and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a cons	aguanco of):					
8/60,	icate be executed physician and s the burial-transit	ajE		I Due ii	7 (01 43 4 001131	equence or).					
2		edicai	[17]	d							
X	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as t	Ľ Mě	IF FEMALE: 23b. Was decedent pregnant		utcome of preg					23d. Date of d	elivery
ň	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 🕱 No	4□Preg	birth 2 ☐ Fe gnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
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Ś	w requires that the de been signed by the s should be detached	by F	Part II. Other significant condition	s contributing to	death but not re	esulting in the u	nderlying cause give	n in Part I.		11	to the cause of death?
cords,	equir sen s nould	ted	Aperipidial o	CONCAIC	11 21	WUSC	, Chill	7/6	1 ☐ Ye	s 2 No 3 F	Probably 4 Unknown
Ö	has b	Completed	renal insu;	TOCICI	704,	Seiwi	re disor	der,	24a. Was an autopsy	prior to	autopsy findings available completion of cause of
<u></u>	ilcian: The lav certificate has rector, page 2	S	hunertersion		<i>J</i> .				perform 1 Yes 2	ed? death? No 1 ☐ Ye	s 2 No
Vital	Attanding Physician: r death. actor: After this certific by the funeral director.	Be	25. s case referred to medical examiner?	Hospital:			Othe	26. Place of Death			
ō	ding Phys T. After this funeral di	- To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of	II 3 DOA	4 X Nursing Ho	me 5 Resider 28d. Describe ho	nce 6 Other (Sp	ecify)
0	iding Phy th. : After thi	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	(Mo	nth, Day Year)	Injury	Work	? ∕es 2 □ No		an injury occurred	
DIVISION	Attandii r death. actor: A by the fu	ifica	3 Suicide 6 Could not determine	ot be 28e. Plac	e of Injury - At	home, farm, str	reet, factory, office	Ī	28f. Location (Str.	eet and Number or F	Rural Route Number,
ב	tal or s afte al Dir	Certification:	4 Hornicide	Duil	ding, etc. (<i>Sp</i> e	ciry)			City or Town,	Siate)	
	To the Hospital or Attandi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	Medicai	29a. Certifier 1 Certifying (Check only one) Medical E	xaminer: On the	ne best of my k basis of exami nner stated.	nowledge, death	h occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	o the	Mec	29b. Signature and title of certifier	A)	A Stateu.		29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
	F 5 F ö		1 // /	1/{/	1 1	1	nvi	59125	/ /	1 .1 .	00.5
			30. Name and address of person w	no completed car	use of death (It	em 23a) (Type,	Print)	1 / 10/		p111 O,	OCCS
_			111 W. Mah	St. Sy	K 31	4 5/1	Lton ML	2192,	/A	Pener Pe	orkis no
	Sta		31. Date filed (Month; Day, Year)	32	Registrar's Sig	nature					
	Registr	ar	APR 14	2005	there !	K ADA	ME)				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 CLARA MAY CHEESEMAN MÄRCH 28. 6:15 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BEVERLY HEALTHCARE HAGERSTOWN WASHINGTON 9. Birthplece (State or Foreign WEST VIRGINIA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Months Days Hours 1 □ M 2 □ F 234-01-8221 99 MAY 12, 1905 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WASHINGTON HAGERSTOWN tX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 750 DUAL HIGHWAY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry CONSTRUCTION Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR FIRM 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES D. BURNS HENRIETTA C. BECKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 N. HIGH STREET, MARTINSBURG, WV 25401 ELAINE MAUCK/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition APRIL 1

Burial 2 □ Cremation 3 □ Removel from State MARTINSBURG, WV ROSEDALE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 1, 2005 ²² BROWN FUNERAL HOME, P.O. BOX 327 W. KING ST., MARTINSBURG, WV 21. Signature of Funeral Service Licenses Charles BOX 821 ne know 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition eime Llans resulting in death) Due as a consequence of): emonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Jasto utestinal Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 2 ER/Outpatient 1 Yes 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural

Physician /Medical Examiner

ner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show solical Examiner must be notified at

other treumatic event, the Medical

5

permit. Page Department of Importent: If any injury or once.

Director

Funerai

Completed by

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. shirt If Item 27 is marked other than "natural", or Items 23s or 28s-f show

Baltimore, Maryland 21215-0036

burial-transit and attending physician for use as the buria signed by the al d be detached fo peen page 2 certificate

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, I

Exami Completed by Physician/Medical Be ٢ Certification:

2 Accident

3 Suicide

29a. Certifier

4 \ Homicide

29b. Signature and title of certifier

8

or Attending

State Registrar

Medicai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D28365

1 ☐ Yes 2 ☐ No

М

t Meritying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hageustam 2/740

368 PIAPIZC nell sveel

31. Date filed (Month, Day, Year) MAR 31 2005



permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natural", or Items 23s or 28e-f show eny injury or other treumatic event, the Modical Ext. Inferforms the notified at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed NOSA #7 Division of Vital Records, P.O. Box 68760,

		1 = State Registrar		Cer	tificate	e of L	Death		A	eg. No.		
ciar lica		1. Decedent's Name (First, Middle, Last)	iam, Doda	on					2. Date of Dea Month	th Day	Year Zaas	3. Time of Death
ine		4a. Facility Name (If not institution, give s		1	4b. City,	Town, or	Location of	Death	~	4c. Cou	inty of Death	
ıl r		5. Social Security Number 226-12-2262 6. Sex Usual Residence of Decedent	7. Age (In yrs. Ia	est birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day June 07	, 19 1 3	9. Birth	nplace (State or Foreign untry) Lrginia
30		10a. State 10b. County MD Washing		, Town or Lo narpsbi								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Dispesso	מו	2556 Chestnut Gro	ove Road		10f. Zip	Code 2 17 8	2		1	og. Citizen Un:		_{untry?} States
in Francisco	2	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates:		Vas Deced f Yes, spec I □ Yes 2		spanic Origin, Mexican, Specify:	in? (Spe Puerto f	city Yes or No- Rican, etc.)	E	Race - Ame Black, White cify: Whi	e, etc.
Total amo	niihiere	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		life. L	lent's Usual kind of word DO NOT us armen	k done d e retired,	urina most i	of workir	ng	16b. Kind o	f Business/I	
	ם	17. Father's Name (First, Middle, Last) Mitt Milton Dodso	on						(First, Middle, I	Maiden Sum		
		19a. Informant's Name/Relationship (Type Arthur W. Dodson)		,					ad, Sha			
		20a. Method of Disposition 1 🛭 Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State Sall	ace of Dispos metery, crea IPIES	sition (Nam	e of			ate	20c. Locatio		Town, State
NIIKE:		21. Signature of Funeral Service License	cations that caused the death.	22 N	Name and Melvir	Addres T.	s of Facility Strice R. Char	der (Co., Inc	V-2541	/1	
n II		23a. Part). Enter the disease, or complications, or heart failure. Lift only on disease or condition resulting in death)	cations that caused the death. the cause on each line. Due to (or as a consequence)	tron	- Pa	w	mo	رد				Approximate Interval Between Onset and Death
oi Eveminer		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to for as a consequence Due to ras	202	í		Mal.		Mac c	_100		Year 5
Modical		IF FEMALE:										
1.5		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de. 9 □ Unknown	death 3□	Ectopic pre Other (spe						Date of delived Month	very Day Year
ם אל דים	ca Dy -	Part II. Dther significant conditions con	tributing to death but not resul	iting in the un	derlying ca	use give	n in Part I.		23e. Did tob			the cause of death?
Completed by Dhysicia		0,						_	24a. Was as autops perform	v	b. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
å		25. Was case referred to medical examiner?	lospital:			Othe			(Check only on			
ation. To		1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	R/Outpatient 28b. Time of Injury		c. Injury Work	4 🔲 Nurs	2	ne 5 ☐ Reside 8d. Describe ho			ify)
Cortification.		3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, larm, stre	et, factory,	office		2	8I. Location (St. City or Town	reet and Nu , State)	mber or Rur	al Route Number,
Modical	Calcal	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death on and/or inv	occurred a estigation,	t the time	e, date and inion, death	place, a	nd due to the ca d at the time, da	iuse(s) and ate and plac	manner as s e, and due s	stated. to the cause(s)
M	IAP	29b. Signature affititle of certifier	Bolel				number 568	32		9d. Date sign		
	30, Name and address of person who completed cause of death (Item 23a) (Type, Print) William F. Bodenheiner, no 9 Saint Paul Street, Boonsharo, no, 21713										0,21713	

State Registrar 31. Date liled (Month Pap Year)

5H-0

Pogistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

				State of Mary		Certifica				Reg. No	15	12762
	Physicia	n	1. Decedent's Name (First, Middle, Last)						2. Dete of De Month APRIL		005	3. Time of Death O
- day	/Medica	al -	EDNA MAE DAYTON 4e Fecility Neme (If not institution, give st	reet end number)				4b. City, Town, or				0230
1	Examine	er a	WASHINGTON COUNTY					HAGER			WASH	INGTON
	Funeral Director		213 30 2770		n yrs. last birt 87		or 1 Year Days	If Under 24 Hrs Hours Min		y, Year) 17	9. Birthp	lace (State or Foreign RYLAND
	Mend 1	-	Usuel Residence of Decedent 10a. State 10b. County	10	Oc. City, Town	or Location					1	0d. Inside City Limits
	e Mary	to	MARYLAND WASHIN	GTON			В	OONSBORO				1 ☐ Yes ※☐ No
	ith with the Maryler 23s or 28s-f show ust be notified at	ral Dire	10e. Street end Number 7921 SHARPSBURG PJ					21713		10g. Citizen of V	U.S.	Α.
21215-0020	172 hours after death with the Maryland "natural", or items 23a or 28a-f show relical Examinal must be notified at	Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	!: Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	er in U,S.			dispenic Origin? (\$ an, Mexican, Puer Specity:	Specify Yes or No to Rican, etc.)	Specify	e - Americ k, White,	
15-0	30	eted	15. Decedent's Educa (Specify only highest grede	tion completed)	16e.	Decedent's Usi	ual Occup	pation during most of wo d)	rking	16b. Kind of Bu	isiness/Ind	lustry
212	within jene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)				MAKER			OWN	HOME
	el Hyg other	Be C	17. Fether's Neme (First, Middle, Last)	1017					me (First, Middle,			
Maryland	2 should be filed within 72 hours rand Mantel Hygiene. Is marked other than "natural", raumatic event, the Medical Exa	2	CLINTON JACOB DAY		104	Mailine Address	ns /Stroot		VIRGINIA			Code
	nd 2 sh ulth and 27 hs n r traun		19a. Informent's Name/Relationship (Type CAROLYN D. HEIMBER	RGER, NIEC	E 7	921 SHA	RPSB	URG PIKE	, BOONSE	ORO, MAI	RYLAN	D 21713
Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health and Martiel Hygiene. important: if tem 27 is marked other than any injury or other traumatic event, the Manone.		20a. Method of Disposition 1		cemeter	Disposition (Na y, crematory or R CEMET	other pla	се)	Date 4/4/05	BOONSB	-	wn, State MARYLAND
Balti	permit. Pag Department Important: I any injury o pnce.		21. Signature of Funeral Service Licenses	April 1				ess of Fecility		OLD NAT		
40			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.	e death. Do r	ot enter the mo	de of dyi	ng, such as cardia	c or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	a.t	2 1	EI		ation			 	Olista and Death
	Examiner		diseese or condition resulting in death) e.	F1 1~	e to (or as a	onsequence of):):	12110			<u>L</u>	
	sit ad	lner	b .			Tens						
·	icete be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c.	Du	e to (or as e	consequence of): '				į	
68760,	rtificete be execut ng physician and es the bunal-trar	Medical	Cause (Disease or injury that initiated events resulting in death) Last	Du	e to (or as e c	onsequence of	:					
39 x	± 0 0		d.								†	
Вох	death ce e attandii ed for use	clan		Shouting to death hou	ot seculting in	the underfulne	aguag gir	ran in Part I	23h Did	tobacco use co	atribute to	the cause of death?
P.O.	v requires that tha death cer been signed by the attandin should be detached for use	by Physician/I	Part II. Other significant conditions contr	iouting to death out r	not resulting in	i the underlying	cause gn	ven in raiti.		Yes 2□ No		
	res tha iigned be de	ģ		3.7.00							DAL W	ere autopsy findings
Records,	requires been sign should be	Completed							24a. Was perfo	an autopsy rmed?	avi	ailable prior to mpletion of cause
Rec	e lav has	g							101	Yes 2KNo		death?]Yes 2□ No
	i clan : The certificete rector, peg	Be	25. Was case referred to medical					26. Place of De	ath (Check only o			
) \	S 50	2	1 Yes 2 No	spital: 1 🗆 Inpatient	2 ER/Ou		JUA	-	Home 5 🗆 Resi			1)
n C	ling Aftar fune	ii lo	27. Menner of Death 1 ☑ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Dey Y	ea <i>r)</i> 28b. T	ime of njury M	28c. Inju Wo	ryat rk? ∣Yes 2.∐.No	28d. Describe	how injury occur	.eq	
Division of Vital	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affar complataly filled in by tha funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (rm, street, facto			28f. Location (City or To	Street and Numb wn, Stete)	er or Rura	l Route Number,
u	Hospital of the policy of the	edical Ce	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	clan: To the best of n	ny knowledge	, death occurre	d at the ti	me, date and plac	e, and due to the urred at the time.	cause(s) and ma	nner as si	ated.
	To the H within 24 To the Fl complate	Med	one) 29b. Signature and title of certifier	end manner stated	j.		9c Licens	se number		29d. Date signe		
	5 <u>3</u> 5 8		-tand	when			Do	0 603	96	04/0	110	15
			30. Name and eddress of person who con	pleted cause of deat	h (Item 23e) (Type, Print) (126	00 603 Opa	(Co.	irt	,	1.7.
St	1000		FARID M 31. Date filed (Month, Dey, Year)	32. Registrar's	Signatura	-/-	, .	Hc	gersto	iwa ,1	(1)	21140
	Stat Registra		APR 0 4 20	05 Janeur	1.	parte	1		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Linwood Willis Davis 100 10/0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 1915) 9. Birthplace (State or Foreign Country) Days Hours 1**X** M 2□ F 578-14-6493 89 Yrs. November Washington, D.C Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1XYes 2 No Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9409 Van Buren Street 20706 United States Completed by Funeral 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
D.C.Dept of Corrections 15. Decedent's Education (Specify only highest grade completed) entary/Secondary (0-12) College (1-4or 5+) Forest Haven Center 8th grade Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Peyton Cora Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Davis Williams (Daughter) 9409 Van Buren Street, Lanham, Maryland 20706 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition

1 ♣ Burial 2 □ Cremation 3 □ Removal from State Date April 4,2005 Cheltenham `4 □ Donation 5 □ Other (Specify) Maryland Cheltenham Veterans Cemetery; Maryland 21. Signature of Funeral Service Licensee R. N. Horton Company Morticians, Inc. anda 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 🗌 Inpatient 2 DEN/Outpatient 3 DOA

Physician /Medical Examiner

Funeral

Director

28a-f shoy

Items 23a

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al Hygiene.

and Mental I

it of Health

Injury

Pages

other traumatic event, the Medical Examinar must be notified at

use as the buriat-tran Certification: To death. filled in by

The law requires that the death certificate be executed Division of Vital Records, or Attending Physician: ofter death Director: within 24 hours e completely

Box 68760.

P.O. I

Registrar

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

ompleted cause oldeath (Item 23a) (Type, Print) SIREET

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year) APR 0 1 2005

5 Pending

investigation

6 Could not be determined

Manner of Death

Natural

2 Accident

3 Suicide

29a, Certifie

29b. Signature at

Medical

4 Homicide

32. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

There It food

		1	1 - For State Registrar	State of		d / Depa		of H	ealth a		ental Hy	giene Reg. No.	0.5	12	766
	Physici	an	1. Decedent's Name (First, Middle, L								2. Date of De Month		Year		of Death
*) /Medic Examin	al	David E. Enlow 4a. Facility Name (If not institution, gi		ber)		4b. City,	Town, or	Location o		March 2)5 nty of Dear		AM M
Ą.,		÷ ;	7545 Burch Road						bacc			Char			
E	Funeral Director		5. Social Security Number 6. 215-56-7682	Sex 7 1 M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	Hours 1	Min.	8. Date of Bir (Month, Da eb. 25	th ly, Year) 1951	_Cc	thplace (Star ountry) ennsyl	
	and bw		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation								City Limits
	er death with the Marylan tems 23c or 28a-f show at must be to lifted at	ctor	Maryland Charles		Po	ort Tol	bacco								es 2X No
	with th	Funeral Directo	10e. Street and Number				10f. Zip					10g. Citizen			
	death sms 23	nera	7545 Burch Road 11. Marital Status	12. Was Deced	lent Ever in U.	.S. 13.		0677 ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	Unite	lace - Ame	ncan Indian	,
36	filed within 72 hours after death with the Maryland Hygiene other than "natural", or items 23s or 28s-1 show ent, I've Medical Exa. I wit must be traffiled at	by Fu	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2			ir Yes, spec 1 ∐ Yes 2		Specify:	, Риепо н	Rican, etc.)	Spe	Black, Whit		
Maryland 21215-0036	be filed within 72 hours after tal Hygiene. Id other than "natural, or i event, I am Medical Example.	ted t	15. Decedent's (Specify only highest g	Education	19/0	16a. Dece	dent's Usua kind of wor	l Occupa	tion	t of working		16b. Kind of		nite Industry	
121	within and than "than "t	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT us	e retired)	uring most	OI WOIKII	ig	C	 5		
2 pt	e filed al Hygie other vent,	Be Co	17. Father's Name (First, Middle, Las	<u>1</u>		EIIC	ineer		18. Mothe	r's Name	(First, Middle			lectr	onics
ylai		ToE	Lyle Edwin Enl								ine Lul				
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship Jeffrey S. Enlow		er		-				^{I Route Numb} 「obacco		vn, State, 2 20677		
Baltimore,	es 1 ag of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 (X Cremation 3		20b. F	Place of Dispo emetery, crei					ate	20c. Locatio			
Ĕ	permit. Pages Department of Important: if it any injury or o once.		* 4 □ Donation 5 □ Other (Spec 21. Signature of Furneral Service Lig	ify)	Hui	ntt Cr	ema to	ry			-2005	Waldo	orf, I	MD	
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)	Physician /Medical Examiner		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a	ch line.	h. Do not ent	er the mode	of dying	g, such as o	cardiac or	r respiratory a	rrest,		Approxin Interval I Onset ar	nate Between nd Death
8760,	ate be executed hysician and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseq										
O. Box 6	The law requires that the death certificate te has been signed by the attending physinge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ∏Feta nt at time of d	Ideath 3	Ectopic pre						Date of del	livery Day	Year
ecords, P	w requires that been signed b should be deta	by	Part II. Dther significant conditions	contributing to dea	ath but not res	ulting in the u	nderlying ca	ause give	n in Part I.			obacco use co Yes 2 No		(of death?
Y		Completed									24a. Was autoj perfo		b. Were au prior to death? 1 \(\sum \text{Yes}	utopsy finding completion of	gs available f cause of
Vita	sician: The certificate	o Be	25. Was case referred to medical examiner?	Hospital:		FD/0		Othe	F		(Check only o				
ion of	or Attending Physician: ifter death. Director: After this certific in by the funeral director,	-	27. Manner of Death Natural 5 Pending Accident investigati	28a. Date of (Month	-	28b. Time of Injury		Bc. Injury Work	4 🗀 (40)		28d. Describe	dence 6 00 how injury occ		city)	
Division		Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place	of Injury - At hog, etc. (Specif	ome, farm, str	eet, factory	, office		2	28f. Location (City or To		mber or Ru	ural Route N	umber,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medicel Excore)	Physician: To the teminer: On the base and manner	sis of examina	wledge, death	vestigation,	in my op	inion, deat	d place, a th occurre	and due to the ed at the time,	date and plac	e, and due	to the cause	
/	To To COU	2	29b. Signature and title of certifier	H. Hat	th		0	License	number 3	57		3 3	ned (Monti	Day, Year)
(NB491		30. Name and address of person wh	17	50	1 /	- 1010	to		~	S	20	64	6	
900	Sta Registr		31. Date filed (Month, Day, Year) MAR 3	1 2005 D	gis ar's Signa	ture #	Span	ويا					- /		

				tate of Maryland					2001	1 (1) 200 00 000
			State Registrar		Cen	tificate of D		Reg. I	(U U D	12/5/
	Dhuaiair		Decedent's Name (First, Middle, Last)						Day Year	3. Time of Death
н	Physicia /Medic				Emer_			March 31	2005	22:00 M
	Examin		4a. Facility Name (If not institution, give stree	at and number)		4b. City, Town, or I			4c. County of Death	
			Calvert County Nurs				Frederic		Calvert	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) 9. Birthp	lace (State or Foreign
	Director	-	154-26-8838 Usual Residence of Decedent	91	113.			June 16,	1913 New	Jersey
	and		10a. State 10b. County	10c. City	, Town or Loc	eation			1	0d. Inside City Limits
	Mary	ro	MD Anne Arunde	اد		Dunkir	k			1 ☐ Yes 2X No
	the 28a	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	itry?
	3a o		6346 Northbrook Dr	cive		20754			USA	
	ms 2	Funeral		Was Decedent Ever in U.S Armed Forces?	S. 13. W	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-	14. Race - Americ Black, White,	
9	after or Ita	Fu	1 ☐ Never Married 2 ☐ Married	1 □Yes 2X No If Yes, Give		☐ Yes 2X No	Specify:		Specify:	
9	hours after death with the Maryland tural', or Itams 23a or 28a-f ahow of Ever it wit the rediffed at	d by	3 X Widowed 4 □ Divorced	Year or Dates:					WIII	
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2	filed within 72 Hygiene. ether than "nai ant, I've Medic		17. Father's Name (First, Middle, Last)		1101		18. Mother's Name	(First, Middle, Maid		
timore, Maryland 21215-003	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If itam 27 Is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avant, Ita Medical Ever it are trium for rediffed at	To Be	Stanley	Stypull	kowski		Stepha	nie	Kanick	a
ary	shou nd M mar umat	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	nd Number or Rura	l Route Number, Ci	y or Town, State, Zip	Code)
Š	and 2 lealth a m 27 le		Jean Emer, daught	er-in-law	6346	Northbro	ok Dr.,	Dunkirk,	MD 20754	
Sre	es 1 a of He fitarr roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Rem	20b. Pl	lace of Disposementery, crem	sition (Name of natory or other place) D	ate 20c	Location - City or To	own, State
Ĕ	Pa int		'4 □Donation 5 □ Other (Specify)		ting Me	em. Park	04-04-	-2005 Wh	iting, NJ	
Balt	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other to once.		21. Signature of Funeral Service Licensee	C		. Name and Address		D 7 (tringa MD	20726
	g D ≥ α α		William A.	aron				<u> </u>	wings, MD	20736 Approximate
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	d Insit	듵	cause. Enter Underlying Cause (Disease or injury that initiated events							
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8760,	ate be executed hysician and the burial-transit	dlcal	d							
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<u>a</u> .	d by	Phy	Part II. Other significant conditions contrib	outing to death but not resu	ulting in the ur	nderlying cause give	n in Part I	23e. Did tobace	co use contribute to the	ne cause of death?
ds,	The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physiclan/Med	Dementia.			,		1 🗆 Yes	2 □ No 3 □ Prob	pably 4 Unknown
Sor	r requ	ete						24a. Was an	24b Were auto	psy findings available
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a	n: Th ficate or, pa	e Co	25. Was case referred to medical				26. Place of Death	1 Yes 2	No 1 ☐ Yes	2 L No
\equiv	sicia	00	eyaminer?	pital:	ER/Outpatien	t 3 DOA Othe		A STATE OF THE STA	6 ☐Other (Specif	(v)
of	Attending Physician: or death. actor: After this certific by the funeral director,	To It		28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	at 2	28d. Describe how i		,,
ion	nding tth. r: Afte e fun	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(MONIN, Day 19ar)	Injury		es 2 □ No			
Division of Vital Record	r Atte er dea racto	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
Ö	ital or A									
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical		ian: To the best of my known on the basis of examinal and manner stated.						
	tha tha tha	Me	29b. Signature and title of certifier	Carlo mannor states.		29c. License	number	29d.	Date signed (Month,	Day, Year)
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)	To COU		- Coga	c our	ance	$\sim \mid D \cdot \mid$	50653	7	4-1-2	005
	To To con		30. Name and address of person who comp	pleted cause of death (Item	n 23a) (Type,					005
)	Towith con		30. Name and address of person who comp	Λ	n 23a) (Type, Ch to	Print) Gy	AN -C	sur	ANA	005
	4	ate		Λ	chito	Print) Gy	AN -C	sun	ANA	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Kathryn L. Eveland 2005 April 1345 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 124 North Bohemia Avenue Cecilton Cecil If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Yrs FEB 24, Director 91 Maryland 213-14-3628 Usual Residence of Decedent the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or itema 23a or 28a-f show other treumatic event, the Neutrell Eventual for must be multipled at 1 Yes 2 □ No Directo Maryland Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 Cecil Street 21915 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ent: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Hamilton Rebecca McConnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Eveland, Jr./Son 321 Cecil Street, Chesapeake City, Maryland 21915 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake City, 20a Method of Disposition April 6. Department of H Importent: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cemetery ¹ 4 □ Donation 5 □ Other (Specify) Maryland Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signaure of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ouln Physician Candio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify, Daughter's 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours a Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 140056426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul M. Katz, 5-Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2005 Registrar

		1	For	artment of Health and Me rtificate of Death		ene g. No. 005	12769
			1. Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Yeer	3. Time of Death
п	Physicia /Medic		Ann Vivian Finnacom		April 3		12:50 AMM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			St. Mary's Nursing Center	Leonardtown		St. Mar	
	Funeral		5. Social Security Number 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday,	Months Days Hours Min.	B. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director	-	213-24-3699 74 Trs. Usual Residence of Decedent	Ι Ι Ι	May 10,	1930 Wasi	nington, D.C.
	/land		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Man a-f sh ified	ţo	Maryland St. Mary's Tall Ti	mbers			1 ☐ Yes 2X No
	th the	Directo	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	23a		44378 Finnacom Road	20690		U.S.A.	
	er des tems	Funeral		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f show aumatic event, the Medical Evand and the problified at	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Xividowed 4 Divorced Year or Dates:	1 ☐ Yes XXNo Specify:		Specify:	: + o
8	hour turel		15 Decedent's Education 16a, Dece	edent's Usual Occupation	1	WIL- 16b. Kind of Business/	ite Industry
15	n "ne	plet	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	7		
212	d with giene	Completed		me Maker		Own Home	
Maryland 21215-0036	m - 0 5	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	faiden Sumame)	
<u>a</u>	Menta	70	Edward Ricker	Elsie He			
<u>a</u>	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic es once.		, , , ,	ing Address (Street and Number or Rural			
	and lealth m 27 her tr			3 Lanedon Drive Leo		n, Marylan 20c. Location - City or	
altimore,	ges 1 t of H If ite or ot	- 3	Burial 2 Cremation 3 Hemoval from State	matory or other place)		•	
₫	t. Pa trmen rtent:		'4 □ Donation 5 □ Other (Specify) St. Geo:	rge Catholic 4-7 12. Name and Address of Facility Bri			ee, Maryland
Bal	Dept.		21. Signature of Funeral Service Licensee	DLI		Funeral H	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	P.O. Box 279 Leona			Approximate
Н			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	11 11			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	1 monvers	~ 0		menutal
U	Examiner		Canalana	12. lar hisath	cocer	AL.	4001
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	source (proving)	-000	7	1
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	, ,		/	V
oʻ	an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dical	d				-
9	artifica ing pl		IF FEMALE:				
Вох	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of del Month	ivery Day Year
<u>.</u>	the a	yslc	1 ☐ Yes 2 M No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			
P.0.	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds	uires (signé ld be	d by	Domantia		1 □ Ye	s 2 @ No 3□Pr	obably 4 Unknown
COL	w requir been si should	Completed			24a. Was ar	n 24b. Were au	utopsy findings available
Re	The lav	E C			autops	ned? death?	completion of cause of
Vital Records,		(a)	25. Was case referred to medical	26. Place of Death		PNo 1 ☐ Yes	2 140
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Cher		nce 6 Other (Spe	city)
o t	g Phy ter thi		27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 28 Work?	3d. Describe ho	w injury occurred	
io	Attending r death.	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	Bf. Location (St. City or Town	reet and Number or Ri ı, State)	ural Route Number,
0	itel o irs afi rel Di						
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only (ith occurred at the time, date and place, ar nvestigation, in my opinion, death occurre	nd due to the ca d at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	thin 2 the mplet	Med	one) and manner stated. 29b. Signature and title of pertifier	29c, License number	2:	9d. Date signed (Mont	h, Day, Year)
	₹ <u>8</u> ₹ 8		b all Intro M	D D 0641	9	4-4-1	35
7			30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		1 0 0	2
				Notch Road Hollywoo	d, Marv	land 20636	
	St	ate	31. Date filed (Month, Dav. Year) 32. Resistrar's Signature	heeks			
	Regist	rar	APR 0 6 2005				

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Sylvia Meyer Gasch March 26, 2005 5:30 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XX Yrs Director 578-16-7860 November 23, 1907 Madison Wisconsin Usual Residence of Decedent the Marylend 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other then "natural", or Iteme 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Maryland Montgomery Bethesda 1XX es 2 □ No Director 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? with 5215 West Cedar Lane 20814 U.S.A. deeth by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pagas 1 and 2 should be tiled within 72 hours after onent of Health and Mental Hygiene. ent: If Item 27 is marked other then "natural", or Iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Decedent's Education (Specify only highest grade completed) National Symphony Elementary/Secondary (0-12) College (1-4or 5+) Solo Harpist Orchestra 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Balthasar Henry Alice Ε. Carleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Gasch - Son 5207 Worthington Drive, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit. Pege Department of Importent: If eny injury or once. Metropolitan Crematory March 29,2005 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A., 21. Signature of Funeral Service Licensee a 4739 Baltimore Avenue, Hyattsville, Maryland 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): PNEUMONIA **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner the attending physicien and hed tor use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) الله – المراكبة المر Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 10 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 250No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 No 2 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours at To the Funerel Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) >20, MA 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Germantown MD. 20971 13219 Executive Park Terr, Bao Iruma MO 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 0 1 2005 Registrar

			1 - For State Registrar	State of Marylan	d / Depa		lealth and	Mental Hy	giene Reg. No. 2005	12771
	Physici /Medic		1. Decedent's Name (First, Middle, Las Helen Jean G					2. Date of Dea Month	Day Year よ。2005	1005 M
	Examir		4a. Facility Name (If not institution, give Washington C	ounty Hosita		Hagers		h '	4c. County of De Washin	gton
	Funeral Director		5. Social Security Number 6. Security Number 219-14-6332	7. Age (In yrs. I ☐ M 2\ F 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da Dec. 9		irthplace (State or Foreign Country) MD
	Maryland	tor	10a. State 10b. County Washin		, Town or Lo					10d. Inside City Limits
	th with the 23a or 28s	Funeral Director	10e. Street and Number 11336 Manse R	d.		10f. Zip Code 21	740		10g. Citizen of What C	Country?
9036	4 within 72 hours after death with the Maryland liene. r than "natural", or Itams 23a or 28a-f show the Medical Exam, ar must be rediffed at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐MNo	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify: Wh	ite, etc.
Maryland 21215-0036	I within pene. r than "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	(Give life. As	dent's Usual Occup kind of work done DO NOT use retired Sembly	during most of wor d)	rking	16b. Kind of Busines Ribbon	
yland	be de la	To Be (17. Father's Name (First, Middle, Last) Walter Richar	d Grandstaf	f				Maiden Sumame) 5 Densmor	·e
	nd 2 salth ar 27 fs 27 fs r trau		19a. Informant's Name/Relationship (7 Sandra J. Grove	daughter	128	27 Drap	er Rd.	Clear S	or, City or Town, State, Spring, MD	21722
Baltimore,			20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State St	Paul	esition (Name of matory or other place Cemete:	ry Apri		Clear Sp	
Bal	permit. Page Department of Important: If any injury or	8	23a. Part 1. Enter the disease, or compshock, or heart failure. List only of	1-1-1	17	2. Name and Addre Donald P.O.BOX	Edwin T	hompsor	n Funeral	Home, Inc
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a. He The Due to (or as a consequence of the Court of the	UL Acuience of):	NANS	C DE MI	4	rest,	Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ience of):					
P.O. Box	at the death certific by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ MO 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co			, ,	en in Part I.		obacco use contribute es 2 No 3 F	to the cause of death? Probably 4 Unknown
Vital Records,	0 5 0	Completed	ACUTE ASNAC	PAILURE				24a. Was a autop perfor	sy prior to death?	utopsy findings available completion of cause of
	ysician: Th is certificate director, pag	o Be C	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only or	ne)	
ion of	문 는 E	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	4 □ Nursing H		ence 6 Other (Sp.	ecify)
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str)	eet, factory, office		28f. Location (S City or Tow	itreet and Number or F n, State)	ural Route Number,
	To tha Hospital or within 24 hours after To tha Funaral Dir completely filled in	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exem	sicien: To the best of my know iner: On the basis of examinat and manner stated.	vledge, death ion and/or in	occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier			29c. License		2	29d. Date signed (Mon	
•			30. Name and address of person who c		23a) (Type,	Print)	1040		04-03-	٥٢
SH	- 3						(NWEST)	MD 21	240	
東	Sta Registr	te ar	31. Date filed (Month Pay Year) 4 2	105 32. Helgistrar's Signat	de jej	with				

			1 - For State Registrar	State of	Maryland / De <i>C</i>	partment of ertificate o		nd Menta	Il Hygiene Reg. No.	2000	12772
	Physici		Decedent's Name (First, Middle, Keller Leon	•	. Sr.			2. Dat	e of Death	3 2005	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution,			4b. City, Tow	n, or Location of	Death	4c.	County of Death	
			Washington Cou	inty Hospi	tal		gerstow			Wash	ington
	Funeral		,	. Sex 7. 1 X M 2 □ F	Age (In yrs. last birthda	Months Da	ys Hours	Min /Mo	e of Birth nth, Day, Year)	Cot	place (State or Foreign untry)
	Director		216-22-9116 Usual Residence of Decedent		77 Yrs.			Jar	1.15,192	8 Ma	ryland
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heath and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-1 show or other treumatic event, the Marifical Exaft are must be notified at	by Funeral Director	10a. State 10b. County Maryland Wash 10e. Street and Number	ngton	10c. City, Town or	Villiams	е		10g. Citi	zen of What Cou	
	s 23a	ra	16842 Edward [21795	0.40		US.	
036	ours after de 'el', or Items Exament	by Fune	11. Marital Status 1 □ Never Married 2 ◯ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	ДNo	3. Was Decedent of If Yes, specify 0		n? (Specify Ye Puerto Rican, i	s or No- etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036	filed within 72 ho Hygiene. ther than "natur int, the Mydical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		or 5+) (G	cedent's Usual Ocive kind of work do	ne during most d tired)	of working		nd of Business/l	_{ndustry} Manufacturer
р 5	filed Hygid Sther		8 17. Father's Name (First, Middle, La	est)		4a i n†enar		s Name (First,	Middle, Maiden		Manuraciuiei
/lan	utd be Mental rrked c	To Be	William Henry	Gesford,	Jr.		Beul	ah Ire	ene Bom	berger	
ar	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ailing Address (Str	eet and Number	o <i>r Rur</i> al Route	Number, City o	r Town, State, Zi	
Baltimore, N	permit. Pages 1 and Dep riment of Health Importent: If item 27 any injury or other tronce.		Helen E. Gesfor 20a. Method of Disposition 1X Journal 2 Cremation 3 Donation 5 Other (Special Signature Funeral Selfic Li	□Removal from St	20b. Place of Discemetery, of Green I at	Deborne A	place) Park Ap	r.6,200 Home, F	20c. Lo 05 Will P.A.	i amspor	Town, State †, Mary land
	0 0 E € 0		23a. Parti. Enter the disease, or conshook, or heart failure. List or			425 S. Co				amsport	,MD 21795 Approximate
8760,	death certificate be executed Amedical Amedical Action and Action use as the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence of):	anholi	The Land	for a			Interval Between Onset and Death
O. Box 68	death certifi e attending od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 Fetal death nt at time of death	3 □Ectopic pregna 5 □ Other (s <i>pecif</i> y				23d. Date of deliv Month	very Day Year
rds, P	es tha igned be de	by	Part II. Other significant condition	s contributing to dea		underlying cause	given in Part I.	23	e. Did tobacco u		the cause of death?
of Vital Records,	The law ate has b page 2 st	Completed	Kyperternia	<u> </u>					a. Was an autopsy performed?	death?	topsy findings available ompletion of cause of
/ita	sician: T certifical rector, p	Be	25. Was case referred to medical examiner?	Hospital				f Death (Chec		-	
Division of	ding Phys n. After this funeral dir	ertification; To	1 Yes 2 No 27. Manner of Death 1 Note of Death 2 Note of Death 3 Suicide 6 Could no	28a. Date of (Month,	Day Year) Injui	e of 28c. I	Other: 4 Nurs	28d. De	scribe how injur	y occurred	
DIVI	tel or Attender safter deatles of Director:	Certifle	3 Suicide 6 Could no 4 Homicide determin	289, Flace 0	f Injury - At home, farm, g, etc. <i>(Specify)</i>	street, factory, off	Ce		ation (Street an or Town, State		ral Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical E.		est of my knowledge, de is of examination and/or r stated.	investigation, in n	ny opinion, death		e time, date and	place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	_		1	ense number			e signed (Month	
			- enti	MD		0	18019		APR	14 3. 3	2 00 5
ŚН	4		30. Name and address of person w		mo 34	o mu	- 6 5 7	MAG	ERSTO	wa n	40 21740
	Sta Regist		31. Date filed (Month, Day, Year)	2005	gistrar's Signature	Sperke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registres Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 8:00 AM 2005 28 /Medical ocation of Dec.

If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 2, 15 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** AGNES HOSP ITAL BALT If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** 7Yrs. Months Days 1 M 254 F 218-62-506 Director ingINIC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show "natural", or Items 23e or 28e-f show Ba Yes 2 □ No Ma Completed by Funeral Director 14 -1 more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5505 WORTH 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Item any injury or other treumetic event, the Medical Examines once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐Yes 2 No If Yes, Give Year or Dates: Specify: Black 3. Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewi ome 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lone NUCI 2 00 000 19b. Mailing Address (Street and Number or Rural + ute Number, City or Town, State, 10 Code) 2120 7 Prila ud her Baltinove NRSSO 5505 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-2-05 Blackstone New Kospect Booken. * 4 ☐ Donation 5 ☐ Other (Specify) EGGLESTON FUMBE U. 21. Signature of Funeral Service Licensee helly Sell TEARMUTTLE UN 23901 MAIN St Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stage Physician one yeur /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical as t IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 **→** No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Hospital or Attanding 1 Matural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a Medicai 1 🕒 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number P16698 March 28, 2005 Mulu House completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Avenue Baltimore, MD 21229 900 Caton Ahmed Dr. Nadeen 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

APR 0 1 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	state of Mary		tificate of D		Re	g. No.2 UU5	12774
	Physici		1. Decedent's Name (First, Middle, Last) Charles Green	1				2 Date of Death Mau60th 2	,Day2005 Year	1349P.
	/Medic Examir		4a FEINCE GEORGES HOS		ter	Cheverly	ocation of Death		Prince og	ëorges
	Funeral Director		377 00 7720	7. Age (li	n yrs. last birthday) 54 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV • 0 •	9. Bin 1950 Was	thplace (State or Foreign purity) Shington, D. C
	yland how		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	8e-f s	Director	D.C.		Washingt	on				1 A Yes 2 □ No
	with the same or 2	Dir	10e. Street and Number 4016 Pennsylvania	Ave. S.E.		10f. Zip Code 20020	0		g. Citizen of What Co United Sta	•
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23a or 28e-f show eny injury or other treumatic event. It is Medical Examination treatmet in indiffed at once.	Completed by Funeral		. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	li li	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto		14. Race - Ame Black, Whit Specify: B1a	erican Indian, e, etc.
15-0	n 72 h "netu edicel	letec	15. Decedent's Educa (Specify only highest grade of	tion ompleted)	16a. Deced	lent's Usual Occupation kind of work done dur OO NOT use retired)	on ring most of worki	ng 1	6b. Kind of Business/	Industry
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nd	2 should be filed within and Mental Hygiene. is marked other than eumatic event, Ita Ma	Be	17. Father's Name (First, Middle, Last)			11		(First, Middle, M	aiden Sumame)	
<u> </u>	should and Men marke umatic	၉	Herman J. Green 19a. Informant's Name/Relationship (Type	Print)	10h Maile			J. Hinto		
	and 2 s ealth an n 27 is i		Bernice F. Green						City or Town, State, 2	D.C. 20020
altimore,	Pages 1 and 2 nent of Health of Health shrt: If item 27 ary or other trues.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren ' 4 ☐ Donation 5 ☐ Other (Specify)	2	Ob. Place of Dispos	sition (Name of natory or other place)		ate 2	Oc. Location - City or Suitland,	Town, State
Balt	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licensee		22 7	Lexander :	S Facily ope	Funeral	Homes, P.A	١.
	* .		23a. Part1. Et er the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the	WORS	538 Maribo	oro Pike	/Forestv	ille, Md.	20747 Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a co	onsequents of):	Gang	Lev V	Curel	2	
	nsit	Examiner	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	Dire to (or as a do	insaquence of:					
68760,	rtificate be executed ng physician and as the burial-transit	Aedicai Exa	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
P.O. Box 68	ath cer ttendir or use	Physician/Med	IF FEMALE: 23c. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Records, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contri	puting to death but no	ot resulting in the un	derlying cause given i	in Part I.	23e. Did toba	No 3 □ Pro	the cause of death?
	Physicien: The law n this certificate has be al director, page 2 sh	Completed	·					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of 2 No
 	Physicien: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 XYes 2 No	pital:	2 ER/Outpatient	Othor		(Check only one)		
Division of Vital	fing After	tion: T		28a. Dite of Injury	28b. Time of	28c. Injury at Work? M 1 Yes	∞ 2	8d. Describe how	ce 6 Other (Spec	ify)
DIVIS	el or Attendi s after death. I Director: A id in by the fu	Certification:	3 Suicide 6 Could not be	28e. Place of njury - building, etc. (S	At home, farm, stre		-	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	dical	29a. Certifier 1 Certifying Physics 2 X Medical Examiner	an: To the best of my: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the time, estigation, in my opini	date and place, a ion, death occurre	nd due to the cau	se(s) and manner as a and place, and du	stated. the cause(s)
	With	Me	29b. Signature and title of certifier	NUS		29c. License no		290	n Date signed (Month March 27,	, Day, Year) 2005
	(3)		30. Name and address of person who comp	leted cause of death	(Item 23a) (Type, F	^{Print)} 111 Penr	n Street	Baltim	ore, Maryl	and 21201
:	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 2005	32. Registrar's S	ignature	2)				

			1 - For State Registrar	• •	nd / Depa	artment of Health and rtificate of Death	Mental Hy	_	12775
	Physicia		Decedent's Name (First, Middle, La Mary	Elsie	Gre	een	2. Date of Dea	28, 2005 Year	3. Time of Death 3:35 A M
	/Medic Examin		4a. Facility Name (If not institution, giv Southern Maryland	d Hospital		4b. City, Town, or Location of Deat Clinton		4c. County of Death Prince Geo	orges
D	uneral irector		5. Social Security Number 6. S 217–34–0322	To Age (In yrs	. last birthday) 68 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min N		4, 1936 Mar	place (State or Foreign intry) yLand
Maryland	e-f show	ctor	10a. State 10b. County Maryland Prince (ity, Town or Lo inton	ocation			10d. Inside City Limits
th with the	23a or 28 ist be no	Funeral Director	10e. Street and Number 8500 Mike Shapiro	Drive Apt.107		10f. Zip Code 20735		10g. Citizen of What Cou USA	intry?
at y (allice 2.12.13-0000) should be filed within 72 hours after death with the Maryland	Department of results and wellers rygients. Department of results and wellers rygients. By injury or other treumatic event, the Medical Examinar must be notified at 200s.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: Black	, etc.
within 72 ha	then natur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) Collage (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) al Worker	rking	16b. Kind of Business/li Prince Georg Government	•
uld be filed	Mental ryg arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last Andrew	Savoy		Hester	,	Maiden Sumame) Proctor	
and 2 sho	m 27 is ma her treuma			Brooks Daught	8500	ng Address (Street and Number or R Mike Shapiro Dr sition (Name of	Apt107	Clinton, Mar	yland
mit. Pages 1	riment of r rent: If ite njury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	Removal from State Un	cometery, creation Bet	matory or other place)		20c. Location · City or T Brandywine	
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ite be executed	ysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b					
The law requires that the death certifica	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year
quires that	n signed by uld be deta	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause given in Part I.		obacco use contribute to	
The law requ	n. After this certificate has been si funeral director, page 2 should	Completed							opsy findings available ompletion of cause of
Physicien:	is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	Othor	ath <i>(Check only o</i>	ne) dence 6 □Other (Speci	fy)
= E	am. r: After this ie funeral di	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe h	now injury occurred	
To the Hospitel or Attending	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office	28f. Location (S City or Tow	Street and Number or Rur vn, State)	al Route Number,
e Hospi	Funer Funer letely fill	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the ourred at the time, o	cause(s) and manner as a date and place, and due t	stated. o the cause(s)
Toth	To th comp	Me	29b. Signature and title of certifier			29c. License number	28-1	29d. Date signed (Month,	Day, Year)
IR			30. Name and address of persign who	completed cause of death (Ite	om 23a) (Type,	Sura Hy	Pal Chi	r kn, M.D	20735
	Sta Registr		31. Date filed (Month, Day, Year) APR 0	32. Registrar's Sign	nature &	Sperle			

	-	For State Registrar	State of Maryla		ertificate o			Reg. N	2005	12776
Physicia	an	Decedent's Name (First, Middle, Las	•				2 Date of D Month	OD.	ay / Year	3. Time of Death
edic	al .	Baby Boy Hec	incenc.	1	1 db 62 Tour	n, or Location	Janu Janu		c. County of Dea	05/1 A
min	er	THE JOHN	S HOPKINS	Hosp	AL2 A	Himi	ore of Ita	1	c. County of Dea	au 1
		5. Social Security Number 6. Se none	7. Age (In yi	rs. last birthda Yrs.	Months Da		Min. (Month, C	rth ay, Year	9. Bi	rthplace (State or Foreig country) aryland
		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location					10d. Inside City Limit
	tor	MD Freder	lck		Frederic	k				1 ☐ Yes 2X N
	Director	10e. Street and Number			10f. Zip Cod			10g. C	itizen of What C	ountry?
		806 Gabriel Court			Man Decedent	21702	sining (Consilie Van as N		USA 14. Race - Am	orican Indian
	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	10.5.	If Yes, specify C		rigin? (Specify Yes or N an, Puerto Rican, etc.) r:	10-	Black, Whi	ite, etc.
	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		edent's Usual Oc e kind of work do		st of working	16b.	Kind of Business	s/Industry
	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use re	tired)	-			
	Be Co	none r 17. Father's Name (First, Middle, Last)	ione	_ no	iie	18. Moth	ner's Name (First, Middl		none n Sumame)	
	ToB	Harry Hechel 19a. Informant's Name/Relationship (7		19b. Ma	iling Address (Str		ather Curat		or Town, State,	Zip Code)
		Johns Hopkins Ho	spital		-		Baltimore,	_	21287	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 XOther (Specify	Removal from State	o. Place of Dis cemetery, cr	oosition (Name of ematory or other	f place)	Date	20c. I	Location - City o	r Town, State
		21. Sign to a of Euneral Service Licen:	ade pipecto	or S	22. Name and Ad State Ana Saltimore	dress of Faciliation Towns I	Board 655 W 21201	. Ва	ltimore	Street
	Examiner	23a. Part 1. Enter the disease, or companies, wheat failure. List only of limediate Cause (Final disease or condition resulting in death) Squarially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	equence of):		Lab	,			Approximate Interval Between Onset and Death
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	ysicla	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 2□Fe 4□Pregnant at time o 9□Unknown		☐Ectopic pregna ☐ Other (specify				Month	Day Year
	by	Part II. Other significant conditions co	ontributing to death but not r	resulting in the	underlying cause	given in Part			_	o the cause of death?
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	<u>۲</u>	1 Yes 2 No	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpati	BIL 3 DOA		ursing Home 5 Res			ecify)
	Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Year)) Injury	M	njury at Work? 1 Yes 2	No 28f. Location	(Street a	and Number or R	Tural Route Number,
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	a	(Check only 2 Medical Exam	vsician: To the best of my k iner: On the basis of exam and manner stated.							
	edic	one)						00 / 0		
	Medical	29b. Signature and title of certifier			29c. Lic	ense number	CAGI	29d. Di	ate signed (Mon	th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 3 **Physician** Hoowood Oseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury oastal Hospice at the Lake ML Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1**X** M 2□ F Yrs. 79 Director 236-34-5501 9/14/1925 West Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Modical Examinar rivat on multiplied at 1 ☐ Yes 2 ☑ No Director Maryland Wicomico Ouantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21715 Wetipquin Rd. 21856 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Piano Technician Historical Restoration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be f Health and Mental I Leslie J. Hopwood Agnes Ethel May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 ls Jonathan L. Hopwood/son 21715 Wetipquin Rd., Quantico, MD 21856 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ξ ŏ 4/1/2005 permit. Page Department Important: If ⁴ 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service License 22. Name and Address of Facility any teell Holloway Funeral Home Professional Association 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician 201 disease or condition resulting in death) /Medical as a consequence of): **Examiner** wette Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed Due to (or as a consequence of) burial-Box 68760. physician Physiclan/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ Month 4 Pregnant at time of death 5 ☐ Other (specify) P.0. the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, q 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 > Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes No certificate has page 2 1 Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital Other: 0 1 Tyes Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28c. Injury at Work? ate of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred After I Certification: To the Hospital or Attending Injury Natural 5 Pending death. 2 Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

JANA COLLALL, MD 31. Date filed (Month, Day, Year)

APR 0 1 2005

COASTAL HOSIXE

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SAUSBURY MO

		_	For State Registrar		State of	Marylan		artment of H tificate of L				Reg. No.	005	12779
	Physici		1. Decedent's Name (F								Date of De Month	Day	Year	3. Time of Death
	/Medic	al -	William Ben						. I - a a sia		March	29	2005	12:10 AM M
1	Examin	er	4a. Facility Name (If not		e street and nun	nber)		4b. City, Town, or	Location (or Death			ounty of Death	1
			5. Social Security Numb		Sex	7. Age (In yrs. i	last birthday)	Bushwood If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th	Mary's	place (State or Foreign
	Funeral Director		213-22-0754		™ M 2□F	79	Yrs.	Months Days	Hours	Min.	(Month, Da February	ıy, Yea <i>r)</i>	Cot	intry)
			Usual Residence of De	cedent							resi dar j	1,9172	, inc. ,	
	rylan	_	10a. State 10	b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	8a-1 s	Director		t. Mary'	s	Bus	hwood							1 □ Yes 2√X No
	with th		10e. Street and Numbe					10f. Zip Code			ŀ	_	n of What Cou	untry?
	ours after death with the Marylan rai', or itams 23a or 28a-f show Exerciner must be notified at	Funeral	22670 Maddo	x koad	12 Was Dece	dent Ever in U.	S. 13.V	20618 Was Decedent of Hi	ispanic Ori	igin? (Spe	cify Yes or No	USA - 14	. Race - Amer	ican Indian,
	ter de	Fun	1 Never Married	2√ Married	Armed For	rces?	ļ	Was Decedent of Hi f Yes, specify Cuba			Rican, etc.)		Black, White	, etc.
98	urs a	5	3 Widowed 4	**	If Yes, Giv Year or Da	8 **		1 ☐ Yes 2 🛣 No	Specify:			S	pecify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show the Medical Exercities must be routiled at	Completed		Decedent's E	ducation ade completed)		16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during mos	t of workir	ng	16b. Kind	of Business/l	ndustry
2	within ene. than "	nple	Elementary/Seconda		College (1	-4or 5+)								
	77		9 17. Father's Name (Firs	et Middle I ast	1		Meat C	utting Mana		er's Name	(First, Middle	Groo		
and	be d la	Be C	Hiram Hewit		,						Roe Long		,	
Maryland	E B B B B	ပ	19a. Informant's Name		Type, Print)		19b. Mailin	ng Address (Street a					Town, State, Z	ip Code)
	od 2 lith a 27 is r tra		Helen Cecel	ia Hewit	t/Wife		22670 1	Maddox Road	, Bush	wood,	Marylan	d 2061	L 8	
Je,	of Heal		20a. Method of Disposi		70	20b. P	Place of Dispo	sition (Name of matory or other place	e)	D	ate	20c. Loca	ition - City or 1	Town, State
E	Pages nent of ant: If it		1 XBurial 2 □ C 1 □ Donation 5 □			State	red Hear	rt Cemetery	A	pril 1	L, 2005	Bushwo	ood, Mary	1and
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funer	al Service Lice	nsee			. Name and Addres		Hat			er Funera	al Home, P.A.
	70 E 2 9	Ш	micha	el Teen	in Han	dener>	7	. O. Box 27					20650	
			23a. Part1. Enter the c shock, or heart fa	ilure. List only	one cause on e	aused the death	h. Do not ent	er the mode et dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Fin disease or condition resulting in death)	al	a. 1710	wow	ucce	cert va	w	_				16 will
	/Medical Examiner	П	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(To o	or as a conseq	uence of):	mana 0	DOM	MONT	lia			Z6 mil
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	uted d ansit	Examine	Sequentially list condit if any, leading to imme cause. Enter Underlying Cause (Disease or injust that initiated events	ng iry	CD)	word	il at	tionh	٠ -					Z6Mil
o,	axec an an rial-tr		resulting in death) Last	·	Due to (or as a conseq	uence of):	. 0	0					
8760,	The law requires that the death certificate be axecuted the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical			_ d									
9	leath certifica attending ph	Med	IF FEMALE:											
Вох	ath ce	lan/	23b. Was decedent pro in the past 12 mo			irth 2 ☐ Feta	Ideath 3	Ectopic pregnancy	,			23	d. Date of delimental delimen	very Day Year
o.	he de the s	ysic	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	0	9□ Unkno	ant at time of down	leatii 5	Other (specify)						
٥.	es that the de igned by the a be detached		Part II. Other significa	nt conditions	contributing to de	eath but not res	ulting in the u	nderlying cause give	en in Part I	l.	23e. Did	tobacco use	contribute to	the cause of death?
ds	quires n sigr	d by	Corona	my	aver	700	Kas	و,			1 🗆	Yes 2 🗗	No 3□ Pro	obably 4 Unknown
Records,	w requir	Completed	Husert	tendo	on	1					24a. Was		24b. Were au	topsy findings available
9	The law te has	mo	the home	Ouse	Jeni	à					auto perfo 1 ☐ Yes	ormed?	death?	ompletion of cause of
Vital	iician: Th certificate rector, pag	a)	25. Was can eferred	to misclical					26. Place	e of Death	(Check only			
> 10	Physician: r this certifica ral director,	OB	examin ? 1 \(\text{Yes} \) 2 \(\text{No} \)		Hospital: 1 🗆	npatient 2 🗆	ER/Outpatier	nt 3□ DOA Oth	er: 4□ Nu	ursing Hor	ne 5 Aesi	dence 6 [Other (Spec	rity)
0	ding Pi		27. Manne of Death	5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	Wor			28d. Describe	how injury	occurred	
Sio	Attanding ir death. actor: After by the fune	cat	2 Accident 3 Suicide	investigation in		of laine. At h	ome form str		Yes 2 🗌		28f Location /	Street and	Number or Ru	ral Route Number,
Division	or At after of Dirac in by	Certification;	4 Homicide	determined	buildi	ng, etc. (Specif	(y)	reet, factory, office			City or To			
	spital ours ours raral filled		29a. Certifier 1	Certifying P	hysicien: To the	best of my kno	owiedge, deat	h occurred at the tin	ne, date ar	nd place, a	and due to the	cause(s) a	nd manner as	stated.
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	edical			miner: On the b			vestigation, in my o						
	To the To the Comp	M	29b. Signature and title	e of certifier				29c. Licens				29d. Date	signed (Month	Day, Year)
			MAD	240		3		りつ	198	1		4	-4-	-05
			30. Name and address											
			Michael S. 31. Date filed (Month.			22576 Ma		Blvd., Sui	te 354	, Cali	tornia,	MD 20	619	
	Regist	ate rar	31. Date filed (Month	PR 4	2005	Silver.		feel						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Пау Month Year **Physician** Francis Aloysius 3, 2005 4:10 AM April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 214-30-0410 July 15, 1932 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hygiene. snt: If item 27 is marked other then "neturel; or Items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "neturel", or items 23e or 28e-f show other treumetic event, the Modical Examinating must be notified at 1 Tiyes 2 No Director Maryland St. Mary's Mechanicsville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 40122 Holt Road 20659 U.S.A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1XX Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Foley Holt Helen Rustin ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar importent: If item 27 Is any injury or other treuonce. George F. Holt / Brother P.O. Box 7 Morganza, Maryland 20660 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace 4-9-05 Helen, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signeture of Funeral Service Lie P.O. Box 279, Leonardtown, Maryland 20650-0279 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. LEUKENIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off Examiner burial-transit Due to (or as a consequence of): attending physicien Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Cther (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 🗌 Yes 2E No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ္ဂ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? e Hospitel or Attending Pl 24 hours after death. e Funerel Director: After t Certification: 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide To the Hospitel
within 24 hours a
To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number
DSG 096 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 4.4.05 who completed cause of death (Item 23a) (Type, Print) TITREE NOTCH RD HOLYWOOD MA 31. Date filed (Month. Day, Year) histrar's Signature State APR 0 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 March 17, Physician 4:00 p M Norma Mae Harrison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Clinton Nursing Home & Rehab. Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Sept. 29,1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K Days Hours North Carolina Director 245-48-8971 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 ie marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at 1√EYes 2 No Directo Maryland Prince George Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8600 Mike Shapiro Drive 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I limportant: If Item 27 is marked other than "natural", or Item any injury or other traumatic event 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) Private Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Davis Babger Macklin ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie M. Jackson / Sister 5707 Ramblewood Ave. Clinton, Md. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 3/26/2005 Clinton, Va. 21. Signature of Funeral Service Licensee Alexanders S. Pope Funeral Home sette 5538 Marlboro Pike Forestville, Md. 23a. Part / Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 99 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗆 No 1 ☐ Yes 2X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral I 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) MAR 3 1 2005 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15mAil M. KALOKOH 1647 BENNING Rd NF # 304 WASHIC 20032 2. Registrar's Signature

29c. License number

MD 2158

29d. Date signed (Month, Day, Year)

March 29, 2005

			1 — For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	4005	12783
	Dhusia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi			ARGROVE		March 2		4:00A M
	Examir	ner	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea	th	4c. County of Death	
	Formaria)		9305 Utica Plac 5. Social Security Number 6. Sex		Springdale If Under 1 Year If Under 24 Hrs	8 Date of Birth	P.G.	ace (State or Foreign
N	Funeral Director	П	577-90-3068	IM 2□E Yrs.	Months Days Hours Min			Carolina
	p.		Usual Residence of Decedent			100/20/1	959 N. C	arorria
	anylar show	2	MD P.G.	10c. City, Town or to Sprine			10	d. Inside City Limits
	the M	Director	10e, Street and Number	301111				1 X Yes 2 □ No
	with se or	ā	9305 Utica Pla	G0	10f. Zip Code	10g.	Citizen of What Countr	y?
	death ms 23	Funeral			20774 Was Decedent of Hispanic Origin? (S	Specify Yes or No-	U.S.A.	n Indian
9	after or Iter	프	1 Never Married 2 Married	Armed Forces? 1 ∐Yes 2 X No	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, et	
93	ours :	d by	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 🌠 No Specify:		Specify: Bla	ck
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural; or Items 23e or 28e-f show imatic event, Ita Medical Examinating the notified at	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Giv	edent's Usual Occupation e kind of work done during most of wo	rking 16b	. Kind of Business/Indu	istry
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ary		-	19a. Informant's Name/Relationship (Typ	pe, Print) 19b. Mail	ing Address (Street and Number or Ri			Code)
	and 2 ealth a n 27 is		Christopher M. Har		Utica Place; Spr			
ore,	- ± 5 to		20a. Method of Disposition	20b. Place of Disp			. Location - City or Tow	n, State
altimore,	Pages ment of ant; if its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		0/05 Ri	verdale, Ma	arvland
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signal of uneral Service License	е 2	2. Name and Address of Facility Freeman Funeral S	ervices	•	
	90 E 9 0		Jul adricipi	el leci -	P. O. Box416: Sui	tland, Mar	yland 2075	52
27			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death. Do not en e cause on each line.	iter the mode of dying, such as cardia	or respiratory arrest,	la la	Approximate Interval Between Onset and Death
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- Ø		er	Sequentially list conditions, b.	Die to (or as a nonevoluence of).				
	uted d ansit	Examiner	Sequentially list conditions, I ary, leading to amendiate cause. Enter Underlying Cause (Disease or injury that indiated events					
ó	exec an an rial-tr		resulting in death) Last	Due to (or as a consequence of):				
8760	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d.					
Q	antifica ing pl e as t	Med	IF FEMALE:					
Box	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of delivery	٧
	at the de by the a stached f	hysician/Me	1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death 5 [9 Unknown	Other (specify)		Month Da	ay Year
a.	res that the igned by be detact	٥	Part II. Other significant conditions cont	tributing to death but not resulting in the i	inderlying cause given in Part I	23e Did tobacc	o use contribute to the	cause of death?
ecords,	uires I sign Id be	d by	_		,	1 ☐ Yes		- 2 · · ·
Ö	w require been si should b	lete				24a. Was an		
T T	The law ate has page 2 s	ompleted				autopsy performed		letion of cause of
Vital		e C	25. Was case referred to medical		26 Place of Dec	th (Check only one)	No 1 Yes 2	□ No
	d is	OB	examiner? 1 ☐ Yes 2 🛣 No Ho	ospital:	Other		6 ☐ Other (Specify)	
וס ר		T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in		
0	Attending r death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident Investigation	(World), Day Youry	M 1 Yes 2 No			
DIVISION	al or Attend after death I Director: / d in by the f	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural R	oute Number,
ם	ital o	O					•	
	Hospital 24 hours a Funeral I	edicai	Check only 2 Medicel Examin	cian: To the best of my knowledge, deat er: On the basis of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu-	, and due to the cause rred at the time, date a	(s) and manner as state and place, and due to th	ed. e cause(s)
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Da	
	- s + ŏ) (ma	' Lul	D0057475	-		
)	(10)		30, Name and address of person who com	npleted cause of death (Item 23a) (Type		0	3-31-20	
			Ari D Fishman	M.D. 2141 K	Street, N.W.	# 707 k	lashington.	DC ROD37
	Sta	_	31. Date filed (Month, Day, Year)	27. Registrar's Signature	- 11.00	,- /		
	Registra	ar	MAR 3 1 2005	Blown Is Do	1		_	

Physician //Medical Examiner The state Registrar I. Decedent's Name (First, Middle, Last) Hyder Johnson Houston 4b. City, Town, or Location Ft. Washington Hospital Ft. Washington Ft. Washington Funeral Director France Social Security Number 578-32-1999 Usual Residence of Decedent Certificate of Death 4b. City, Town, or Location Ft. Washington Ft. Washington Ft. Washington Johnson Houston Ab. City, Town, or Location Ft. Washington Ft. Washington Johnson Johnson Houston Ab. City, Town, or Location Ft. Washington Formal Months Days Hours Johnson	2. Date of Dea Month March on of Death	28, 2005 4c. County of Death Prince Ge	3. Time of Dealth 11:40PMM					
Medical Examiner Sommson Houseon House	on of Death CON der 24 Hrs. 8. Date of Birth	4c. County of Death Prince Ge						
Funeral Director 4a. Facility Name (If not institution, give street and number) Ft. Washington Hospital 5. Social Security Number	on of Death CON der 24 Hrs. 8. Date of Birth	4c. County of Death Prince Ge						
Funeral Director 5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea	der 24 Hrs. 8. Date of Birth	h 9. Birth	Prince George's					
Director 578-32-1999 1 M 2 F 85 Yrs. Months Days Hours	der 24 Hrs. 8. Date of Birth (Month, Day 10 / 28 / 1	v. Year) Cou	orge's					
5/6-32-1999 A 65	10/28/1	19 10212	place (State or Foreign ntry)					
	10a. State 10b. County 10c. City, Town or Location							
O			10d. Inside City Limits					
oklahoma Oklahoma Oklahoma City			Yes 2 □ No					
Oklahoma Oklahoma Oklahoma City Oklahoma Oklahoma Oklahoma City 106. Street and Number 826 N.E. 65th St. 73105 11. Marital Status Amed Forces? Amed Forces? 1 Yes 2X No		10g. Citizen of What Cou	ntry?					
826 N.E. 65th St. 73105		USA						
The second of th	Origin? (Specify Yes or No- ican, Puerto Rican, etc.)	14. Race - Ameri Black, White						
1 □ Never Married 2 □ Married 1 □ Yes 2 1 No If Yes, Give 1 □ Yes 2 1 No Specific Year, or o Dates:	eify:	Specify: Blac	1.					
10a. State 10b. County 10c. City, Town or Location 0klahoma City 10e. Street and Number 10f. Zip Code 826 N.E. 65th St. 73105 11. Marital Status 1 Dever Married 2 Married 1 Divorced 1 Di		16b. Kind of Business/Ir						
(Specify only highest grade completed) (Give kind of work done during milite. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	nost of working							
5+ Psychiatric Social	1 Worker	Counseling						
T. Father's Name (First, Middle, Last) 18. Mol	other's Name (First, Middle,	Maiden Surname)						
James Royal Johnson Dor								
10a. State 10b. County 10c. City, Town or Location 10d. Zip Code 10d								
Hyder Hope Houston/Daughter 3008 Raymond Ct. I	7-7-7-	on , MD , 20 / 44 20c. Location - City or T						
Hyder Hope Houston/Daughter 3008 Raymond Ct. If 20a. Method of Disposition 1 Burial 20 Cremation 3 Removal from State 4 Donation, 5 Other (Specify) 21. Signatur, Funeral Service Ligensee 22. Name and Address of Fac	1	Edgewater, M	_					
21. Signatur / Funeral Service Ligensee 22. Name and Address of Face								
21. Signatur Funeral Service Ligensee 22. Name and Address of Face 6160 Oxon Hil	orge P. Kalas Il Road Oxon I	Hill, Maryla	and 20745					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.			Approximate Interval Between					
	+ Failu	18	Onset and Death					
/Medical resulting in death) Due to (or as a consequence of):	7 7 667 7 5		10.10.05					
. Sequentially list conditions D.	1seasc		loyears					
fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of):								
The past 12 months? 1 any, leading to immediate cause were provided for the past 12 months? 1 any, leading to immediate cause as a consequence of): 2 and the past 12 months? 3 and the past 12 months? 4 and pregnant at time of death and time of death and the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Dther significant conditions contributions contributions contributions contributions c								
edicate								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Van Olive		23d. Date of deliv	ery					
in the past 12 months? 1 Yes 2 No		Month	Day Year					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Unknow								
Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Par Breast Cancer Interstital Luns disease		bacco use contribute to t es 2 □ No 3 □ Prot	2/					
Interstital Luns disease								
Breast cancer Combieted by Breast Line Breast Congress Enterstital Lung disease Arthritis	24a. Was a autops perfori	sy prior to co	ppsy findings available mpletion of cause of					
	1 ☐ Yes	2 No 1 ☐ Yes	2 No					
	ace of Death (Check only on Nursing Home 5 Reside							
Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 1 1 1 1 1 1 1 1 1		ow injury occurred	y)					
The state of Injury 28d. Imperor 1 28d. Imperor 28d. Imperor 1 28d. Imperor	□No							
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	28f. Location (St City or Town	treet and Number or Rura n. State)	al Route Number,					
To least a series of the serie			<u>, </u>					
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a company one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date a company one one of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company one of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company one of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company one of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company one of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company one of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company one of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date a company of the pasts of examination and/or investigation.	and place, and due to the ca death occurred at the time, d	ause(s) and manner as s late and place, and due to	tated. the cause(s)					
27. Manner of Death The Natural 2 Accident 3 Suicide 4 Homicide 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, do and manner stated. The Natural 2 Accident 3 Suicide 4 Homicide 4 Homici		29d. Date signed (Month,						
		, /	_					
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	50270	2/24/0	J					
DEBORAH M. THOMPSON, MD 5100	30296 Auth Way	Suitla	nd, MD					
State 31. Date filed (Month, Day, Year) 2. Registrar's Signature MAR 3 1 2005								

		1 - For State Registrar	State of Maryland		artment rtificate					Reg. No.	2005	12	784
Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) Annie Bell H As Facility Name (If not institution, give s	luguley treet and number)		4b. City, T	own, or L	ocation of I	Ma	Month Arch	26 ^{Day}	2005 County of Deal	3. Time of 6:45	a ^M
Funeral Director		Manor Care 5. Social Security Number 200-20-6117	7. Age (In yrs. In 91	a <i>st birthday)</i> Yrs.	Large		If Under 24 Hours	Hrs. 8. Min.	Date of Bi (Month, D	irth		eorge hplace (State of untry) bama	or Foreign
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Prince G		, Town or Lo	ocation							10d. Inside C	ity Limits 2 □ No
be filed within 72 hours after death with the Maryland tal Hygiene. dig other then "neturel", or tems 23s or 28e-f show event, the Medical Examinational Local Section 1	by Funeral Director	10e. Street and Number 4601 Deepwood Co	Durt 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	1	10f. Zip (20 ** Was Decede If Yes, specif	720 ent of Hist fy Cuban	panic Origir , Mexican, I Specify:	n? (Specif Puerto Ric	y Yes or N an, etc.)	US2	zen of What Co A 14. Race - Ame Black, Whit Specify: B1	ncan Indian, e, etc.	
within 72 hours after lene. rthen "neturel", or Ite trs Medical Evanina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 5th grade	cation e completed) College (1-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use	done du retired)	ring most o				nd of Business tral M		l
2 should be filed and Mental Hygin is marked other eumatic event,	0	17. Father's Name (First, Middle, Last) George Huguley	no Cristi			1	18. Mother's Miss	s Name (F souri	Tı	icke:		Zin Codel	
t and 2 sh Health and Item 27 is m		19a. Informant's Name/Relationship (Ty) John L. Huguley 20a. Method of Disposition 1	Sr.(Nephew)		•								
permit. Pages 1 and 2 should be Department of Haalth and Manta Importent: If item 27 is marked eny injury or other treumatic evones.		1 Maurial 2 □ Cremation 3 □ R 1 □ A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Gre	enwo	od Ce 2. Name and	met o	eryAp	pril Tyrc	01,0 one 3	5 Pi J. Yo	ttsbur oung F ington	un Sei	rvic
Physician /Medical		23a. Part1. cnlt r the disease, or corresponding to the disease, or corresponding to the disease or condition resulting in death)	cation that caused the death ne cause) in each line. 2	not en	ter the mode						rngcon	Approximal Interval Bet Onset and Days	te tween
ate be executed whysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t									- 10	
death certific le attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	⊒Ectopic pre ⊒ Other (spe						23d. Date of de Month	,	Year
The law requires that the take has been signed by the page 2 should be detach	by	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	underlying ca	use giver	n in Part I.		1 🗆	Yes 2		robably 4X	Unknown
	e Completed	25. Was case referred to medical					26. Place of	of Death //	per 1 ☐ Yes	opsy formed? 2 A No	prior to death?	utopsy findings completion of c	available ause of
Phys this	To B	examiner? 1	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2Ba. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		A Other Bc. Injury Work	r: 4 🔀 Nurs	sing Home		sidence	6 □Other (Spe y occurred	cify)	
or Atten ifter deat Sirector: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	y)			-		City or To	own, State			nber,
To the Hospitel within 24 hours a To the Funerel (Medical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, dea tion and/or in	nvestigation,	in my opi	inion, death	place, and occurred	d due to the	e, date and	and manner as I place, and du e signed (Mon	to the cause(s)
To Toon	2	29b. Signatura and title of certifier 30, Name and address of person who of	ompleted cause of death (Item	23a) (Type	D	322					h 29th		
St Regis	ate	Richard J. Fe1 31. Date filed (Month, Day, Year) MAR 3 1 2005	dman, M.D. 9	500	Annap	01i	s Roa	ad S	uite	A-4	¶ T _{anl}		d

DHMH 17 Rev 1/2001

ORIGINAL

С			1 - State Unpend Item Registrar	State of N 23a&27 per	Maryland / Dep r me G842	artment of F	lealth and Beath	Mental Hy	giene Reg. No. 200	5 12785
		ryki	Decedent's Name (First, Middle,					2. Date of De	ath	3. Time of Death
	Physic /Medi		EARL LEONDI	AS	HAYES			April	5, ^{Day} 2005 Yes	16:18p M
	Exami		4a. Facility Name (If not institution,		r)		Location of Dea		4c. County of D	
2			1908 Porter Ave			Suitlan			Prince (
25	Funeral Director		5. Social Security Number 223 40 6352 Usual Residence of Decedent	5. Sex 1 √ M 2 □ F	Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	Birthplace (State or Foreign Country) RGINIA
,	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-1st	ctor	MARYLAND PRINCE	GEORGES	SUITLA	ND				1x Yes 2 □ No
	with th	Director	10e. Street and Number 1908 PORTER AVEN	IITE		10f. Zip Code 207	1.6		10g. Citizen of What	Country?
	eath is 234	Funeral	11. Marital Status	12. Was Deceder	t Ever in II S 13			Specify Ves or No	USA	merican Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat", or Items 23a or 28a-f show amportant: if Item 27 is marked other than "hattrail Examinar must be notified at 2006.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	^{□No} 1957−	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2ሺ No	Specify:	to Rican, etc.)	Black, W	hite, etc.
Maryland 21215-0036	72 hou	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occup	ation	rkina	16b. Kind of Busine	ss/industry
2	within ne.	mple	Elementary/Secondary (0-12)	College (1-4o	r 5+) life.	DO NOT use retired	()	rking		
7	filed v Hygie ther t	ပ္	17. Father's Name (First, Middle, La	2	Elect	rician	18 Mother's Na	me (First Middle	Governme Maiden Sumame)	ent
<u>a</u> n	ld be ental ked o	To Be	Howard Hayes	, and				an Ander:	,	
ary	shou and M s mar	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street			ar, City or Town, State	a, Zip Code)
	and 2 salth a n 27 ls er trau		Myra Hayes/wife		1908	Porter A	zenue Su	itland, l	MD 20746	
altimore,	of He		20a. Method of Disposition ty□ Burial 2 □ Cremation 3	☐Removal from Stat	20b. Place of Dispo			Date	20c. Location - City	or Town, State
ţ	t. Pag tment tant: jury o	l a	'4 □ Donation 5 □ Other (Spe	cify)	Maryland	l Vet. Cer	n. 4-	11-2005	Cheltenham	, Maryland
Bal	permit. Departi Importi any inj		21. Signature of Funeral Service Lie	ous co-To		2. Name and Address Suitla			Funeral H	
	Enysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	Atheros	sclerotic Ca				rest,	Approximate Interval Between Onset and Death
	Examiner				is a consequence of):					
	D =	ner	Sequentially list conditions, if any, leading to immediate out to E. it at Underlying Cause (Disease or injury	Due to (or a	is a consequence of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	cate be executed physician and the burial-transit	dicai E		d.	is a consequence of):					
P.O. Box 68	The law requires that the death certifics to has been signed by the attending plage 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
	w requires that been signed b should be dete	by	Part II. Other significant conditions	s contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
Vital Records,	, ut C	Completed						24a. Was a autop: perfor	sv prior t	autopsy findings available o completion of cause of ? es 2 \(\) No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only or		
of	ing Phys After this uneral di	lon: To	1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	iury 28b. Time of	28c. Injun Work	at		ence 6 X Other (Sp ow injury occurred	pecify) At Scene
Division	spital or Attending hours after death. heral Director: After filled in by the fune	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of I	njury - At home, farm, str atc. (Specify)		/es 2□No	28f. Location (S City or Town	treet and Number or in, State)	Rural Route Number,
	FU 4	ledical C	29a. Certifier (Check only one) 1 Certifying 2X Medical Ex	Physician: To the best aminer: On the basis and manners	it of my knowledge, death of examination and/or in- stated.	n occurred at the time restigation, in my op	e, date and place pinion, death occu	o, and due to the corred at the time, d	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Mu/	M	29c. License		2	29d. Date signed (Mo.	
R			30. Name and address of person wh	to completed dauge of	death (Item 23a) (Type,	Print)			April 6,	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 8 20		trar's Signature		n Street	Baltim	ore, Mary	land 21201

Physician		Decedent's Name (First, Middle, L					2. Date of D Month	Day	Year	3. Time of Deat
/Medica	1.	ISAIAH MAURICE H			dh City Town	al castian of F	APRIL		2005 nty of Death	11:43p
Examine	r '	4a. Facility Name (If not institution, g. FORT WASHINGTON		rep	4b. City, Town, o				CE GEO	RCES
Funeral				In yrs. last birthda	y) If Under 1 Year	If Under 24	Hrs. 8 Date of B	irth		lace (State or Fore
Director		217-21-2605	¹X M 2□F 16	Yrs.	Months Days	Hours	JUNE	12,1988	MARY	LAND
*	-	Usual Residence of Decedent 10a. State 10b. County	T ₁	IOc. City, Town or	Location				10	0d. Inside City Lin
f show		MARYLAND PRINCE		FORT WAS						1 √ □Yes 2□
tor 28e-f shot be neither at	Director	10e. Street and Number	GEORGES	TOKI WAS	10f. Zip Code			10g. Citizen o	of What Coun	try?
23a or	2	612 CEDAR AVENUE			2074	4		UNITED	STATE	S
or itams	by Funeral	11. Marital Status 1 Marital Status 1 Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		ace - America lack, White, e	etc.
		15. Decedent's	Education	16a. Dec	cedent's Usual Occur	pation		16b. Kind of	Business/Ind	
C = 0	ompleted	(Specify only highest g	grade completed) College (1-4or 5+)	life	ive kind of work done DO NOT use retired	during most of d)	f working			
) -	8TH GRADE		STU	JDENT / CO					D SERVICE
d e d	o Re	17. Father's Name (First, Middle, La: UNKNOWN	st)			KIA LA	Name (First, Midd. A TARSHA	HILLIARI	0	
of Health and Meritem 27 Is marker other traumatic		19a. Informant's Name/Relationship LAURA J. SWANN /		612	CEDAR AVE		ORT WASHI	NGTON, N	MARYLA	ND 2074
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec	city)	cemetery, c	sposition (Name of trematory or other place VELERANS CEM		Date RIL 12,2005		NHAM,	
Department Importent: It any Injury o once.		21. Signature of Funeral Service Libra C. THORNION	JOHNSON MO0583]	22. Name and Addre LHORNION FUNI 3439 LIVINGS	ERAL HOM	E, P.A. INDIAN HE	AD. MARYL	AND 206	540
ysician Medical		Immediate Cause (Final disease or condition resulting in death)	d		Arrythmia		rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Medical caminer	Exam	disease or condition	b. Due to (or as a control of con	Cardiac			Total Of Tespitatory	allest,		Interval Between
ohysician and the burial-transit	dical Exam	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events)	b. Due to (or as a control of con	Cardiac consequence of): consequence of):			TOTAL OF THE SPIT ALOTY	23d. [Date of delive	Interval Between Onset and Death
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ate has Leen signed by the attending physician and imposes 2 should be detached for use as the burial-transit and imposes the burial-transity and imposes the buria	e Completed by Physician/Medical Exam	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Class (Disease or miury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a domination of the control of the	Cardiac consequence of): consequence of): pregnancy Fetal death me of death in the consequence of the conseq	Arrythmia 3 Ectopic pregnance 5 Other (specify) e underlying cause give	y ven in Part I. 26. Place of	23e. Dic 1 [23d. [I tobacco use co] Yes 2 No is an opsy formed? 2 □ No	ontribute to the state of the s	ry Day Year e cause of death abby 4 Unknowsy findings availanpletion of cause
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Its after death. The Director: After this c-ruificate has usen signed by the attending physician and in properties of the funeral director, page 2 should be detached for use as the burial-transit in properties of the funeral director, page 2 should be detached for use as the burial-transit in properties of the funeral director.	To ee Completed by Physician/Medical Exam	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dease, University that indiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a decomposition to be as a contribution to the page of the contribution to t	Cardiac consequence of): consequence of): consequence of): pregnancy Fetal death me of death not resulting in the 28b. Time Injury At home, farm, (Specify) my knowledge, de examination and/or	Arrythmia 3 Ectopic pregnance 5 Other (specify) e underlying cause give tient 3 DOA other (specify) street, factory, office eath occurred at the tir investigation, in my of the specific content of the spe	y 26. Place of ther: 4 \(\text{Nursion} \) ry at rk? ly es 2 \(\text{No} \) me, date and popinion, death	23e. Dic 1 24a. We aut plat Yes 1 Death (Check only ing Home 5 Re 28d. Describe 28f. Location City or T	23d. [I tobacco use co] Yes 2 No Is an opsy formed? 2 No or one) sidence 6 Co e how injury occ (Street and Nurown, State) e cause(s) and a date and place 29d. Date sign	ontribute to the sound of the s	ry Day Year e cause of death ably 4 Unknowsy findings availant pletion of cause 2 No (Route Number, ated, the cause(s)

		- For	artment of Health and Mer	ntal Hygien Reg. N	2005 12787
		Decedent's Name (First, Middle, Last)	2.	Date of Death	3. Time of Death
Physicia		James Warren Huber, Sr.	Ma	rch 29	2005 11:00 A M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		lc. County of Death
	•	10 Lums Road	North East	c	Cecil
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 0.1 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea	
Director		213 05 8183 91 Yrs. Usual Residence of Decedent	J	an. 24,1	914 Pennsylvania
land ow		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
h the Maryland r 28a-f ehow	ţo	Maryland Cecil North East			1 □Yes XXNo
ith the or 28s	Directo	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
th wit	aiD	10 Lums Road	21901	Uni	ted States
r dea	Funerai	11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2. Married 1 □ Yes 2. No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
d 21215-UU36 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tlems 23a or 28a-f ehow ont, the Modical Examination unable maillied at	by Fi	1 □ Never Married 2 2 2 Married 1 □ Yes 2 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify:
IZI 5-UU36 ithin 72 hours aft no. han "natural", or han "natural", or	ed b		dent's Usual Occupation	16b	White Kind of Business/Industry
Z1Z15-0 1 within 72 ho piene. r than *natur	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	755.	The state of the s
d with	mo	Elementary/Secondary (0·12) College (1·4or 5+) 11 Carpe	enter	R	ailroad
2 - 0 W	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maide	en Surname)
arylar should be nd Menta marked umatic ev	To	Winfield H. Huber	Hattie Ja	ne Stern	s
2 8 8 8 B		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural R	oute Number, City	or Town, State, Zip Code)
1 and 1 and 1 Health Health tem 27 other tr		Lauraine F. Huber/Wife 10 Lu	ms Road, North East	. Maryla	nd 21901
0 0		20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cremation 20b. Place of Disposition 20b. Place	position (Name of April 2		Location - City or Town, State
Baltime permit. Pag Department Important: II any Injury o		`4 □Donation 5 □Other (Specify) Harmony (owingo, Maryland
Balt permit. Departr Imports any inji		7/1/1/		ch Funer	
40244		23a. Part1. Enter the disease, or complications that caused the death. Do not en	27 South Main Street		ast,Maryland 21901 Approximate
		snock, or neart failure. List only one cause on each line.	/		Interval Between Onset and Death
Pnysician /Medical		disease or condition	east FALURE		1 monity.
Examiner		Due to (gras a consequence of):	e mouanoine	110	
	ē	Securation list panettions frank, leading to immediate cause. Enter Underlying Cause (Disease or injury	C My c cantog ing C	1011-911	0/107
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.			
'60, be executed sician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
8 / 6U, sate be executed hysician and the burial-transit	dicai	d.			
ntifica ng ph ng ph		IF FEMALE:		i	
BOX 60 death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	☐Ectopic pregnancy		23d. Date of delivery Month Day Year
the deg	/sici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (specify)		
± pg pg	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
dS,	l by			1 ☐ Yes	2 No 3 Probably 4 □Unknown
Hecords, P. The law requires that the has been signed by age 2 should be deta	Completed			24a. Was an	24b. Were autopsy findings available
The lav	mp			autopsy performed?	prior to completion of cause of death?
	e Co	25. Was case referred to medical	26. Place of Death (C	1 Yes 2	to 1 Yes 2 No
r VITA ysician: is certific director.	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Othor	19 255	6 □Other (Specify)
g Phy er this	 	27. Manner of Death 28a. Date of Injury 28b. Time of	The state of the s	. Describe how inj	
DIVISION (I or Attending F after death. Director: After d in by the funer	Certification:	2 Accident investigation	M 1 Yes 2 No		
Or Attendate deat Director:	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
ital or ral Di	Cer				
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier Certifying Physicien: To the best of my knowledge, deat (Check only 2 Medical Exeminer: On the basis of examination and/or in			
To the within 2 To the I	Med	one) and manner stated. 29b. Signature and title of petitilier	29c. License number	294 17	Date signed (Month, Day, Year)
T wit		Los. Orginature and title of returner			
		11-11-	201855		13/100
K		20 Name and address of parker who completed course of death /link 2001 True	D01858	3	131/05
5		30. Name and address of person who completed cause of death (Item 23a) (Type,	D01858	5/1	705 m D
<i>5</i>	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Sept. 1) (Type, Sept. 2) (Type,	DO1858 Print) 204 Scoth 57	Elk	mm)

James A. Hooper 05-2231 DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For	State of Maryland /	Department of Health and M	lental Hygiene	10700
1 -	For State Registrar		Certificate of Death	Reg. No.	12/88
1. [Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	-	1.7		Month Day Year	- N

Physician	
/Medical	_
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "naturat", or Items 23e or 28e-f show empirious or other traumatic event, the Modical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

James Arnold Hooper March 29								1 29.	2005	905 a M	
4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death 4c. County of Death						
	49372 Old Barnes W				Ridge	KUndarOdi	Uro Lo - L		St. Mary's		
	5. Social Security Number 6. Sex 7. Age (In yrs. last to 220-82-2199 1 № 2□ F 34				Onths Days	Hours N	Min. 8. Date of (Month,	Birth Day Yea 2	1970 Ma	hplace (State or Foreign untry) ryland	
	Usual Residence of Decedent 10a. State 10b. County	or Locati	ion					10d. Inside City Limits			
5	MD St. Mary		oc. Only, Town	ity, Town or Location						1 ☐ Yes 2X No	
ect	10e. Street and Number		Ridge				Dg. Citizen of What Country?				
					20680				USA		
Funeral Director	49372 Old Barnes Way 11. Marital Status 12. Was Decedent Ever in U.: Armed Forces?							ecify Yes or No- 14. Race - American Indian,			_
	1 Never Married 2 Married		If Yes, specify Cuban, Mexican, Puerto Hican, etc.) 1 ☐ Yes 2 No Specify:				Black, White, etc.				
d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 12 Year or Dates:			195 241 NO	Зр о спу:			Specify: white		
ete	15. Decedent's Educ (Specify only highest grade		16a.	(Give kind	s Usual Occup of work done	during most of	working 16b. Kind of Business/Industry				
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		auto parts clerk & delivery man auto parts							
Be C	17. Father's Name (First, Middle, Last)						Name (First, Mid		n Sumame)		
0	Samuel Hooper,	Jr.				Eliza	abeth .	h Ann Mister			
	19a. Informant's Name/Relationship (Ty)	pe, Print)						-	or Town, State, Z	ip Code)	
	Shelly A. Hooper,	wife	49 20b. Place of			nes Way	, Ridje		20680		_
	20a. Method of Disposition 1	lemoval from State	cemeter	y, cremato	ory or other plac	'		1	Location - City or	,	
ľ	'4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	99 —	мс. па		ame and Addres		-02–2005	Ov	vings, MI)	_
	1 4.00 con 26					_ ~	ome, P.A	., Ow	ings, MI	20736	
	23a. Part1. Enter the disease, or compli	icalions that caused th	e death. Do n	not enter th	ne mode of dyin	g, such as card	diac or respirator	arrest,		Approximate	
	Immediate Cause (Final disease or condition	shock, or heart failure. List only one cause on each line. Interval Between Onset and Death									
	esulting in death) Due to (or as a consequence of):										
_	a. Acute coronary thrombus Due to (or as a consequence of): b. Hypertensive almost elevate conditions, Sequentially list conditions,										
e l	Sequentially list conditions, any, leading to immediate ause. Enter Undertying Cause (Disease or injury										
xal	that initiated events resulting in death) Last	Due to (or as a c	consequence o	of):							
an/Medical Examine		1									
Medi	15.555										_
an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy								23d. Date of deliv	*	
SIC	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tin 9□Unknown	ne of death	5 🗆 Ot	her (specify)					nth Day Year	
yny	Part II. Other significant conditions con	tributing to death but i	not resulting in	the under	rlying cause give	en in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?	
ed by							1(∐ Yes 2	2 □ No 3 X Pro	obably 4 Dunknown	
Completed					24a. Was an				24b. Were autopsy findings available prior to completion of cause of		
E				_			pe 1 X Yes	topsy rformed? 2 \(\sigma\)	death?	2□ No	
De	25. Was case referred to medical examiner?					26. Place of I	Death (Check on				
1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence									6 ★Other (Spec	ify) at scene	
0	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. T	njury	28d. Describe how injury occurred Work?						
ica.	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, stre			M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Number,			
Serti	4 Homicide determined determined building, etc. (Specify)					City or Town, State)					
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Linury at Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route City or Town, State) 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred											
one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Ye										, Day, Year)	-
Lasha AM as and									h 30, 20	05	
30. Name and address of person who is impleted cause of death (Item 33a) (Type, Print)											
		enberz	M.D		111 Pe	enn Str	eet Bal	timo	re, Mary	land 21201	
е	31. Date filed (Month, Day, Year)	32. Registra	Signature								1

State Registrar

APR 0 1 2005

10

			1- For State of Maryland / Department of Certificate of Certificat	of Death	Re	g. No.	5 2789
	Physici	an	1. Decedent's Nam <i>e (First, Middle, Last)</i> MARY JANE HALL		2. Date of Death Month MARCH		3. Time of Death
	/Medic	al	TI	n, or Location of Death	MAKCII	4c. County of	
4	Examin	er	FREDERICK MEMORIAL HOSPITAL FREDE			FREDE	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Birth	C	Birthplace (State or Foreign
	Director		220-34-3240 1 Months Da	ys Hours Min.	Jan. 16	, 1912	Maryland
	p .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	shov	_					1 ☐ Yes 2 ☑ No
	the N	ect	Maryland Carroll Keymar 10e. Street and Number 10f. Zip Coc	Α	10	g. Citizen of Wh	
	with Sa or	ä		757	"	U.S.A.	
	death ms 2%	Funerai Director		of Hispanic Origin? (Spec Juban, Mexican, Puerto F	cify Yes or No-	14. Race -	American Indian,
9	or Ite		1 Never Married 2 Married 1 Yes 2XNo 1 Yes 2XN		lican, etc.)		white, etc. white
200	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show ited Exatri normust be maitified at	d by	3X Widowed 4 Divorced Year or Dates:				
15-	d within 72 hours after death with the Marylan jeen : r then "neturel", or Items 23e or 28e-1 show the Medical Examinat must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Oc (Sive kind of work of the DO NOTUSE to	cupation ne during most of workin tired)	g 1	6b. Kind of Busi	ness/Industry
12	within ene.	d L	Elementary/Secondary (0-12) College (1-4or 5+) homemaker			Oran.	n home
9	e filed Il Hygi other vent, I	a)	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M		1 HOME
lan'	should be and Mental I marked o	To B	Harry S. Norburry	Olive	Grace	Whi	itelock
10	. nt 99 =		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str.				
e, 7	s 1 and 2 of Health item 27 I		Robert P. Hall, son 9104 Croom F)772 ty or Town, State
Baltimore,	Pages nent of H int: If ite		1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State cemetery, crematory or other	place)			
를			'4 Donation 5 Other (Specify) Metropolitan Cre	The second secon	8/2005	Alexano	rıa, VA
Ва	permit. Departr Imports any inj		// 7/	uneral Home	. P.A.	Owinas.	MD 20736
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure.) List only one cause on each line.				Approximate Interval Between
17	Pnysician		Immediate Cause (Final disease or condition a Gerebrovarcula				Onset and Death
1	/Medical		resulting in death) a. Due to (or as a consequence of):	, = 0(0=0)			canp_
В	Examiner	_	Sequentially list conditions, b. Hypertension				
	ed sit	ine	Sequentially list conditions, if any leading to immediat cause. Enter Undertying Cause (Disease or injury				
	xecut and al-trar	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed the sax been signed by the attending physician and usge 2 should be detached for use as the burial-transit	dicai E					
9	tificate ng phys as the	_ ⊕ :					
Вох	eath certific attending p I for use as 1	an/In	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant	ıncy		23d. Date of	,
	at the dea by the at tached fo	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify 9 Unknown			Month	n Day Year
P.0	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I	23e. Did toba	acco use contribu	ute to the cause of death?
ds,	signe d be d	d by	and the second s	3	1 ☐ Yes	14	□ Probably 4 □Unknown
Vital Records,	w requir been si should	Completed			24a. Was an	24h We	re autopsy findings available
Re	The far ate has page 2	dmo			autopsy perform	pric	or to completion of cause of th?
ta		O	25. Was case referred to medical	26. Place of Death			Yes 2□No
<u>></u>	dis y	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Hom			(Specify)
u of			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury	njury at 2: Work?	8d. Describe hov	v injury occurred	
Sio	Attending Pher death. sctor; After the by the funeral	cation:	2 Accident investigation M	I □ Yes 2 □ No			
Division	or Attencater death Director:	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	ce 2	8f. Location (Stre City or Town,		or Rural Route Number,
	pitel ours a erel (29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the	a time, date and place, as	nd due to the car	ise(s) and mann	er as stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edicai	(Check only one) Check only 2 Medical Examiner: On the basis of examination and/or investigation, in n and manner stated.	ny opinion, death occurre	d at the time, dat	te and place, and	I due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. Lic	ense number			Month, Day, Year)
			► Chm). It mip.	D 21944		3/26/	65
	4.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	N			50 FIS dm, X
	4		Vane J. Crisson MD 1475 Tane	y NVE - ZI	04 1-14	WERICI	70112 gm,)
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vares S. Crisson MD 1475 Tane 31. Date filed (Month, Day, Year) MAR 2 9 2005	20			

			State of Maryland / D				•	
				Certificate of I	Death	Re	g. No U U 5	2790
ı	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Arthur Junior Johnson			2. Date of Death Month March	Day Year 26, 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Dea	
П			Suburban Hospital		Bethesda			itgomery
	Funeral Director		5/8-36-5345	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep. 4,	9. Bir Co 1931 W	thplace (State or Foreign buntry) Iash., DC
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limits
	e Maryli Ba-1 sho	Director	Maryland Prince George's		shington			1 XYes 2 No
	h with th		10e. Street and Number 3021 Tinker Drive	10f. Zip Code	20744	10	g. Citizen of What Co United	ountry? States
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whit	
030	within 72 hours after death with the Maryland liene. than "natural", or Items 23a or 28a-1 show the Medical Erand at must be notified at	by	1 Never Married 2 Married 1 Never Married 2 No If Yes, Give 1 Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:			lack
215-0036	in 72 ho n "natur Aedical	Completed	(Specify only highest grade completed)	Decedent's Usual Occup- (Give kind of work done of life. DO NOT use retired	during most of work	ing	6b. Kind of Business	/Industry
7 7	d within giene. er than "	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Metro Bu	ıs Driver		Pri	vate
פ	be filed value Hygie of other feether	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle, M		
yland	Menta Menta arked	To	Arthur B. Johnson			Magg	ie Chapman	
Mar	permit. Pages 1 and 2 should be file Department of Health and Mental the Important: If Item 27 is marked oth any Injuy or other traumatic even once.		1.12.	. Mailing Address (Street a				
e o	1 and dealth am 27 ther t			2501 - 25th Disposition (Name of	-		Wash., DC	
Baitimore,	nt of I		1 Burial 2 □ Cremation 3 □ Removal from State cemeter	y, crematory or other plac	:e)		· ·	
	artme ortani injury		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	nd Veterans 22. Name and Addres			Chelten uneral Hom	
ä	Dep any		Standary III	C management			wash., DC	
	TEST I		23a. Pan I. Inter the disease, or complications that cause the death. Do r sholk, or heart failure. List only one cause on each line.					Approximate Interval Between
435 epc	Physician		Immediate cause (Final disease or condition September 2015)					Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of	of):				
	Examiner		Sequentially list conditions. b.					
	pe tis	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):				
	be executed Ician and burial-transit	Examiner	that initiated events c	of):				<u> </u>
2	te be executed yslcian and e burial-transit	calE	L _d					
8	tificat ig phy as the	ledic						
X Q Q	leath certificate attending physl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □ Street the first street th	3 Ectopic pregnancy			23d. Date of del	,
	the c by the achec	Physician/Medi	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)		ples as a second	Month	Day Year
ž,	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in Septices Shock, Renat	the underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Š	requ been should	etec	Metabolic acidosis	1112-41	/	24a. Was an		
Vital Records,		Completed by	7/2003/5			autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
/Ita	cian: ertifica ector,	Be (25. Was case referred to medical examiner?			h (Check only one).	
0	Physi this c	7	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Ou		4 Nursing no		nce 6 Other (Spe	city)
	ding F h. After funera	tlon	1 Natural 5 Pending (Month, Day Year) Ir	Time of 28c. Injury Work	Yes 2 No	28d. Describe how	w injury occurred	
DIVISION	or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far			28f. Location (Str	eet and Number or Ru	ural Route Number,
	F 9 F C	Certi	4 Homicide determined building, etc. (Specify)			City or Town,	State)	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge 2 Medicel Exeminer: On the basis of examination and manner stated.	, death occurred at the tin d/or investigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of gertifier	29c. License			d. Date signed (Monta	
			* Security	84	7518		MARCH	27,2005
R	(10)		30. Name and address of person who completed cause of death (Item 23a) ((Type, Print)	Pitel H	401, 10	Coctevri	w 2005)
	Sta •Registr		31. Date filed (Month, Day, Year) MAR 3 1 2005					V-35 L
	~			ALCO COMPANY OF THE PARK OF TH				

DHMH 17 Rev 1/2001

JOHNSON, ARTHUR 3126105 1828

			For State Registrar	State	of Maryla	•	artment <i>rtificate</i>			Mental Hy	giene Rag. No. <i>C</i>	2005	
	Physici	an	Decedent's Name (First, Middle	harles J	osenh K	611v				2. Date of De Month	Day	Year 2005	3. fime of Death 1925 M
	/Medic		4a. Facility Name (If not institution				4b. City. T	own, or Loc	cation of Deatl			ounty of Deal	
	Examin	ier	Harford Me						de Grac				rford
	Funeral		5. Social Security Number	6. Sex		. last birthday)	if Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Big (Month, Da	th Vear	9. Birt	thplace (State or Foreign
	Director		213-44-8675	1 🛣 M 2 🗆 F	56	Yrs.	Months	Days	TOUTS IVIII.	June	21,194	18 81	Maryland
7	D		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	sho	5	,	rford		,,		erdee	on.				1⊠Yes 2 No
	288	Director	10e. Street and Number	11014			10f. Zip 0				10g. Citize	n of What Co	L
3	3a or		27 Hillman Cou	rt				2100	01			U.S.	Α.
	nours aner deam with the Maryland turel', or liems 23a or 28a-1 show al Examinet hast be natified at	Funerai	11. Marital Status	12. Was Dec	cedent Ever in l	U.S. 13.	Was Decede	nt of Hispan	nic Origin? (S	pecify Yes or No o Rican, etc.)	- 14	Race - Ame	
٠	or Ite	正	1 ☐ Never Married 2 ☐ Marr	ied 1⊠Yes	2 No	İ	1 ☐ Yes 2		pecify:	o nican, etc.)		Black, Whit pecify:	
3	ural',	d by	3 ☐ Widowed 4 ☒ Divorced	Year or	Dates: 196	8-72							White
ပုံ	"nat	iete	15. Deceden (Specify only highes	's Education it grade completed)	16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupation done durin	n ng most of woi	rking		of Business/ en Prov	ing Ground
71:	then then	Completed	Elementary/Secondary (0-12) Twelve Years	College	(1-4or 5+)	1	unner				Aberd	deen, I	Maryland
0	De lied winn / 2 nours aner deam win me maryan an Hygiene. A rough at Hygiene. A confert then "natural", or liems 23a or 28a-1 show event, me modified at event, me modified at	BeC	17. Father's Name (First, Middle,	Last)				18.	. Mother's Nar	me (First, Middle	, Maiden Sı	umame)	
/ar	snould be filed within 72 and Mental Hygiene. I marked other then "nat umatic event, it a wide.	To B	E. 1	Ralph Kel	ly					Virgi	nia Ha	11	
Maryland 21215-0036	and I s me		19a. Informant's Name/Relations				•			ıral Route Numb			
≥ ·	and lealth m 27 her tr		Robert S. Kell	y (son)	2004	_			t, Abe	rdeen, I			21001
timore,	If of H If ite or of		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Removal from	State	Place of Dispo	matory`or oth	er place)	04/	Date 03/05		tion - City or	
<u> </u>	rtmen rtent: njury		' 4 □ Donation 5 □ Other (S21. Signature of Funeral Service		R	.A. Ferr	2. Name and		1	03/03	west (lester,	, Pennsylvania
	parmir. Paggs 1 and 2 should be med with papertnent of Health and Mental Hygien Importent: If item 27 is marked other than any injury or other traumatic event, IL 1900.		Thom rus h	. Porte	ana s	_]	Lee A.	Patt	•	& Son Fu	neral 903-0		P.A.
	61119		23a. Part1. Enter the disease, or	700	Approximate Interval Between								
F	hysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Seps. 5										Onset and Death
	/Medical		Due to (or as a consequence of :										30004
H	Examiner	L	Sequentially list conditions,	b									
9	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sug (c	or as a conse	quence oi):							
,	al-trai	xar	that initiated events resulting in death) Last	c	o (or as a conse	quence of):							
20	physician and sthe burial-transit	dicai E		L d									
8	rise dearn certificate be executed y the attending physician and iched for use as the burial-transit	Medi	IF FEMALE:										
ROX	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		utcome of pregr birth 2 □Fet		Ectopic pre	gnancy			230	d. Date of del Month	ivery Day Year
o :	the at	sici	1 Yes 2 No	4□Preg 9□Unki	nant at time of nown	death 5	Other (spec	cify)				MOITH	Day real
7	res triat the de signed by the a be detached f		Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cau	use aiven in	n Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ds,	ulres n sign Id be	d by		Adenoca	viceno	me C	olon			10	Yes 2💢	No 3□Pr	obably 4 Unknown
Records,	w require been sign	leted		Adenoca	rs dory	2=	elur	9		24a. Was	an a	24b. Were au	itopsy findings available
e j	ine iaw requires mat ate has been signed b page 2 should be deta	ompl		100				-			osy ormed? 2.2.No	prior to death?	completion of cause of
		e C	25. Was case referred to medical					26.	. Place of Dea	1 ☐ Yes		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20.110
O T O	th. th. : After this certifical tuneral director, p	To B	examiner? 1 ☐ Yes 2 No	Hospital: 12	inpatient 2	☐ ER/Outpatier	nt 3 DOA	Other:	4 🗌 Nursing H	lome 5□Resi	dence 6	Other (Spec	cify)
	ing ra	 	27. Manner of Death 1X Natural 5 ☐ Pendin	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time o Injury		c. Injury at Work?		28d. Describe			
SIO	tor: /	cati	2 Accident investig	not be			М		2 🗆 No	00/ 1	74	V b D	
DIVISION	or Attendate death Director: in by the	Certification:	4 Homicide determ	100d 280. Plac	e of Injury - At I ding, etc. (Spec	nome, tarm, str eify)	eet, factory,	Office		City or To	vn, State)	vumb o r or At	ıral Route Number,
	to the nospirel or Attenuing ripsicial. within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	-23	29a. Certifier Certifyin	g Physician: To th	ne best of my kn	nowledge, deat	h occurred at	t the time, d	date and place	, and due to the	cause(s) ar	nd manner as	stated.
:	within 24 hours within 24 hours of To the Funeral completely filled	edic	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a control of the cause (s) and man									to the cause(s)	
	To t	Ň	29b. Signature and title of certifie		1 0		29c.	License nui	mber		29d. Date s	signed (Monti	h, Day, Year)
	ALA		15209	ninga	4-15	200	40	04	3115		3-	-31-0	
	11,1		30. Name and address of person 6/5, 5-4	who completed cau	use of death (Ite	m 23a) (Type,	Print)	Gr	ace	MD.	2	1078	
	Sta		31. Date filed (Month, Day, Tear)	2005	Registrar's Sign	rature	Ne!	-					
	Registr	ar	[NI 1) 1	COOL PARTY	The same of the sa	" A							

Date of Dente 3-30-05

		1	For State Registrar		Oldio (or maryia		artment of H rtificate of		a Mental H	ygiene Reg. No.	0000	12702
Ph	ysiciar	_	Decedent's Name (First,	Middle, La	st)					2. Date of D Month	eath Day	/ Year	3. Time of Death
//	/ledica	1	James Francis 4a. Facility Name (If not ins			umber)		4b. City, Town, o	r Location of D	April	01 4c.	2005 County of Death	8:25 P. M
EX	amine	ſ	St. Mary's He			,			rdtown			St. Mary's	5
Fun Dire			5. Social Security Number 217-34-1041	6. 9		7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B Min. (Month, I Sep. 14	irth Day, Year)	9. Birth	
₽.) <u> </u>	Usual Residence of Deced			1.0							
arylar show	Ħ .		10a. State 10b. C	ounty		10c. C	City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 No
he M.	Le nutified	D I		. Mary	s	С	oltons Po				10- 011	izen of What Cou	
with t	1		10e. Street and Number	D.				10f. Zip Code 20626			USA		nury ?
death ms 23	11 MB	-	20410 Coltons Po	JIIIL K	12. Was De	cedent Ever in		Was Decedent of H	ispanic Origin	? (Specify Yes or N		14. Race - Ameri	
ING 21215-0036 be filed within 72 hours after death with the Maryland hal Hygiene. d other then "naturel", or Items 23e or 28e-1 show	g 2	2	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		Armed F 1 X Yes If Yes, G Year or	2 □ No Sive		If Yes, specify Cuba 1 ☐ Yes 2 2 No	Specify:	ueπo Hican, etc.)		Black, White, Specify: Whi	
Maryiand 21215-0035 d 2 should be filed within 72 hours af th and Mental Hygiene. ?? Is marked other then "naturel", or	lied by	Completed	15. De	cedent's E	ducation ade completed	f)		dent's Usual Occup		working	16b. Kii	nd of Business/In	dustry
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d 21 filed wi Hygien ther th	H.		12 17. Father's Name (First, M	fiddle Last)		Pure	chasing Age		Name (First, Middi		Sumame)	
arylan(should be that Mental I	eve c	o Re	Francis DeSalo							Elizabeth B		02	
ore, Maryla Is 1 and 2 should If Health and Men item 27 Is marke	in F	0	19a, Informant's Name/Re				19b. Mailir	ng Address (Street		r Rural Route Num		r Town, State, Zip	Code)
	rtra		Mary Loretta La	wrence.	/Wife		P. O.	Box 3. Col	tons Poi	nt, MD 2062	26		
Ore, es 1 a of Hec titem	othe	-	20a. Method of Disposition				Place of Dispo	osition (Name of matory or other place		Date		cation - City or To	own, State
MOT Pages nent of nut: It it	ury or		1 XBurial 2 □ Crem 1 4 □ Donation 5 □ Ot				-			i1 4, 2005	Leona	ardtown, Ma	aryland
Baltimore, permit. Pages 1 ar Department of Hea Importent: It item:	y inju		21. Signature of Funeral 5	ec ice Lice	nsee		22	2. Name and Addre	ss of Facility	Mattingley-	Gardin	ner Funera	1 Home, P.A.
ш <u>жо</u> е	5 a	4	23a. Party. Enter the disea		Lime	<u></u>				rdtown, Mar		20650	Approximate
Pnysic /Med			Immediate Cause (Final disease or condition resulting in death)		\mathcal{A}	-	-						
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McClain Larcello LaVett March 25, 2005	9:40 P. M Death Birthplace (State or Foreign Country) rginia 10d. Inside City Limits 1 1 Yes 2 No t Country? A. American Indian, White, etc. Black ess/Industry
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Examiner 4b. City, Town, or Location of Death 4c. County of Examiner 4c. County of Examiner 4d. City, Town, or Location of Death 4c. County of Examiner 4c. County of Examiner 4d. City, Town, or Location of Death 4c. County of Examiner 4d. City, Town, or Location of Death 4c. County of Examiner 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. County of Examiner 4d. City, Town, or Location of Death 4d. City, Town, or Location 4d. City, Town, O	Birthplace (State or Foreign Country) rginia 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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Director 579-18-4303 1	rginia 10d. Inside City Limits 1
Usual Residence of Decedent Usual Residence of Decedent 100 City Tourney Legation	10d. Inside City Limits 1
10a. State 10b. County 10c. City, Town or Location 10d. City Code 10d. City Town or Location 10d. City Code	1
D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What	t Country? A. American Indian, White, etc. Black ess/Industry
10g. Citizen of What 10g. Street and Number 1127 42nd Street, N.E. 20019 10g. Street and Number 1127 42nd Street, N.E. 20019 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1. New of Part o	Annerican Indian, White, etc. Black ess/Industry
The property of the property o	American Indian, Vhite, etc. Black ess/Industry
Armed Forces? In Never Married 2 Married White, etc. Black ess/Industry	
Specify: Specify:	ess/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 2 of 1 of 1 of 1 of 1 of 1 of 1 of 1 of	
Elementary/Secondary (0·12) College (1·4or 5+) Taxi Cak Driver Taxi Cak Driver Tonsa Fuqua 19a. Informant's Name/Relationship (Type, Print) Fig. informant's Name/Relationship (Type, Print) Fig. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Route Number, Ci)
Taxi Car Top of A To)
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19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Street and Number or Rural Route Number, City or Town, State Street and Number or Rural Route Number, City or Town, State Street and Number or Rural Route Number, City or Town, State Street and Number or Rural Route Number, City or Town, State Street and Number or Rural Route Number, City or Town, State Street and Number or Rural Route Number, City or Town, State Street and Number or Rural Route Number, City or Town, State Street and Number or Rural Route Number, City or Town, State Street Street and Number or Rural Route Number, City or Town, State Street	
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Edith 1. Walker/Companion 8305 warren Dr., Politiet, Md. 20675	
Edith I. Walker/Companion 8305 Warren Dr., Pomfret, Md. 20675 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City	or Town, State
	le,Md.
20a. Method of Disposition 1 Burial 25 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc. 4/4/05 Beltsvil 22c. Location - City Chesapeake Crematory, Inc. 4/4/05 Beltsvil 22c. Name and Address of Facility H. S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington	.D.C. 20019
resulting in death) Due to (or as a consequence of):	> 15mls.
TF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of Month 23d. Date of Month	delivery Day Year
	te to the cause of death?
Cormany lettery disease 1 Yes 28 No 3 Cormany lettery disease 1 Yes 28 No 3 Cormany lettery disease 24a. Was an autopsy performacy performacy deat a corman lettery deat a co	e autoney findings available
B a g g g g g g g g g g g g g g g g g g	e autopsy findings available to completion of cause of h?
F g g g g g g g g g g g g g g g g g g g	Yes 2□ No
The state of the s	Specify) Friend's Res
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 XNatural 5 Pending (Month, Day Year) 1 Accident investigation 4 1 Yes 2 No	
27. Manner of Death 1 1 2 Natural 2	r Rural Route Number,
29a. Certifier 29a. Certifier (Check only	or as stated. due to the cause(s)
one) and manner stated. 29b. Signature and dittle of certifier 29c. License number 29d. Date signed (M	fonth, Day, Year)
* Kaman K. Tal: D19609 3.28.0	.5
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3503 PERRY STREET, Raman Tuli, M.D. MOUNT RAINIER, MARYLAND 2071	2
State Registrar APR 0 1 2005 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			Certificate of Death		gierie Reg. No. 2011	16 1000
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Mae Virginia Mills	2. Date of Dea Month March	30,2005	3. Time of Death 9:10 am
. 1	Examin		4a Facility Name (If not institution, give street end number) Williamsport Nursing Home 4b. City, Town, or Lo		4c. County of De Washing	
	Funeral Director		5. Social Securify Number 217-28-6598 6. Sex 1 Months Deys Hours Min.	8. Date of Birt (Month, Da Mar 3	9. B 0 , 1927	irthplace (State or Foreign Country) MD
	Meryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Washington Williamsport			10d. Inside City Limits 1 🂢 Yes 2 🗆 No
	th with the 23a or 28 at be no	Funeral Director	10e. Street and Number 154 North Artizan St. 21795		10g. Citizen of What C	ountry?
020	filed within 72 hours effer death with the Merylend Hygiene. ther than "natural", or flems 23a or 28e-f show int, the Medical Examiner must be notified at	þ	11. Maritel Status 1	ecify Yes or No- Rican, etc.)		
Maryland 21215-0020	d within 72 ho piene. r than "natus ine Medical	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade 16a. Decedent's Usual Occupation (Give kind of work do ne during most of working life. DO NOT use retired) Homemaker	ing	16b. Kind of Busines. resider	•
/land	uld be file Ventel Hyg rked othe	ro Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name		Maiden Surname) beth Glad	lhill
, Mar	and 2 sho rath end h		19a. Informant's Name/Relationship (Type, Print) Kay V. Bell daughter 19b. Mailing Address (Street and Number or Rural 10832 Downsville E	Pike Ap	ot22 Hage	erstown, MD
Baltimore,	permit. Peges 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mones.		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) April 2 Cedar Lawn Memorial Pa	2, ^D 2005 ark	20c. Location - City o Hagerst	r Town, State COWN, MD
Balt	permit. Departimports any inj		21. Signature of Funeral Service Licensee 7 22. Name and Address of Fecility Donald Edwin Tho P.O.BOX 310 Clea			
att.	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
A STATE OF THE STA	/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth) a. Congestive heart failure Due to (or as a consequence of):			2 years
100	uted	miner	atherosclerotic heart disc	ease		years
ox 68760,	Attanding Physician: The law requires that the death certificate be executed to death. rideath. actor: Attar this certificate has been signed by the attending physicien end by the funeral director, page 2 should be deteched for use as the buriel-transit	VMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): d.			years
P.O. Box	death	siclar	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco uae contribut	te to the cause of death?
P.O.	that the ned by the detech	y Phy	renal Failure	101	/es 2□No 3⊡/i	Probably 4 Unknown
ecords	aw requires is been sign 2 should be	Be Completed by Physician/N	chronic obstructive gulmonary disease	24a. Was a perfor		Were autopsy findings available prior to completion of cause of death?
a R	t: The ticete ha	S	Parkinsons Disease	1UY		1 ☐ Yes 2 ☐ No
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cent within £4 hours efter death within £24 hours efter death this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be deteched for use	္ရ		me 5 Resid	ence 6 Other (Sp.	ecity)
Divis	al or Atte s efter de il Directo ad in by th	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or F n, State)	lural Route Number,
	in 24 hour in 24 hour he Funera pletely fills	Medical Certification:	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place, a control of my knowledge, deeth occurred at the time, date and place at the control of my knowledge, deeth occurred at the time, date and place at the control of my knowledge, deeth occurred at the time, date and place at the control of my knowledge, deeth occurred at the time, date and place at the control of my knowledge, deeth occurred at the control of my knowledge, deeth occurred at the control of my knowledge, deeth occurred at the time, date and the control of my knowledge, deeth occurred at the control of my knowledge, deeth occurred at the control of my knowledge, deeth occurred at the control of my knowledge, deeth occurred at the control of my knowledge, deeth occurred at the control of	ed at the time, o	late and place, and du	e to the cause(s)
	Vith Vith Community	2	29b. Signature and title of certifier 29c. License number D + 7 + 5		29d. Date signed (Mon	
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	11	March 30,	1-5-00
6	H-3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthea Keither Sand ND Williams Port Nursing	Home, + Mar	yland 21	795
	Sta Registra		31. Date filed (Month, Day, Year) APR Û 1 2005 32. Registrer's Signature)		

DHMH 16 Rev 6/95

		1 - For State Registrar				artment rtificate				1	Reg. No.	2005	1070
Physic	ian	Decedent's Name (First, Middle,								2. Date of Dea Month	ath Day	Year	3. Time of Peath
/Med		Elizabeth Anna Ma								April	6	2005	2:36 P. M
Exami	ner	4a. Facility Name (If not institution,		iber)		4b. City, To			of Death		4c.	County of Deat	h
		St. Mary's Nursin 5. Social Security Number		7. Age (In yrs.	last birthday)		onard Year	Itown If Under	24 Hrs.	8. Date of Birt	h	. Mary's	hplace (State or Foreign
Funeral Director		213-22-2153	1□M 2 X)F	92	Yrs.	Months	Days	Hours	Min.	(Month, Da)	y, Year)	Co	untry)
D		Usual Residence of Decedent									1712	Taly	Tand
show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
Ba-f	ecto	Maryland St. Mar	y's		Valley L								1 ☐ Yes 2√√2 No
with ti	2	10e. Street and Number	_			10f. Zip C					10g. Citi:	zen of What Co	untry?
within 72 hours after death with the Maryland ene. than "patural", or items 23a or 28a-f show to Mouloul Ex. eliner count by coulded at	by Funeral Director	19140 Nick Matting1	y Lane	tent Ever in U	S 13	Was Deceded		nanic Ori	nin? (Sner	rify Yes or No.		J SA I4. Race - Ame	ncan Indian
fier d ritan	F	1 Never Married 2 Marrie	Armed For	ces?	- 1	_	0"		, Puerto F	cify Yes or No- tican, etc.)		Black, White	e, etc.
urs a	þ	3 🖫 Widowed 4 □ Divorced	If Yes, Give Year or Da	9		1 ☐ Yes 28	No No	Specify:				Specify: Wh	ite
72 ho	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual of work	Occupati	ion	t of workin	ia.	16b. Kir	nd of Business/I	Industry
ithin	nple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use	retired)	ing mosi	or working	g			
filed w Hygier other th	ပိ	12			Hom	emaker						wn Home	
be fill	Be	17. Father's Name (First, Middle, L.	ast)				1			(First, Middle,		Sumame)	
should ind Men marka umatic	2	Joseph Russell	o (Time Sciet)		10h Maili		24			ette Bai		T	F 0 41
CA 40 7 40	ŀ	19a. Informant's Name/Relationshi Lynn Marie Boothe/Ni										Town, State, Z	ip Code)
1 and Health em 27	1	20a. Method of Disposition	tece	20b. F	Place of Dispo	Box 53 sition (Name	of			ryland ate	20692 20c. Lo	cation - City or	Town, State
Pages nent of I int: If it iry or o		1 XBurial 2 Cremation		itate	cemetery, crei	•							
arime orden in ury		' 4 ☐ Donation 5 ☐ Other (Special Service ☐		St.	George	's Cemet Name and	-	of Facility	pril 1	2,2005	Val 1e	y Lee, Ma	aryland
permit Depart Import any in		14	J .		1	Matting1	ey-Ga	ardine	er Fun	eral Hom	e, P.	A., Post	Office Box 70
		23a. Part1. Enter the disease, or c	complications that ca	used the deat		Leonardt er the mode					rest,		Approximate
Physician		shock, or heart failure. List o Immediate Cause (Final	nly one cause on ea	ich line.	1.0	e,							Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Como	or as a conseq	uence of):								2 mis
Examiner			- Wal	des	made	Tun							5-4-1
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	r as a nonseo	tienne of):							-	
cutec nd transi	Examiner	Cause (Disease or injury that initiated events	c										
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (d	r as a conseq	uence of):								
ate be ex hysician the buria	dicai		d								_		
eath certifica attending ph for use as ti	Physician/Med	IF FEMALE:											
ath c	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	Ideath 3	Ectopic preg					2	3d. Date of delinerMonth	very Day Year
the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊔Pregna 9□ Unkno	nt at time of d wn	eath 5L	Other (spec	ify)						,
res that the de signed by the a be detached f	P	Part II. Other significant condition	' Is contributing to dea	ath but not res	ulting in the u	nderlying cau	se diven	in Part I.		23e. Did to	bacco us	se contribute to	the cause of death?
sign d be	d by	alsheuner	~ Dense	contin	8-/	ad un	111	16		1 □ Y	es 2t	Mo 3⊟Pro	bably 4 Unknown
w require been si should b	ete				1	CO (100		-	24a. Was	1	Odb Word aut	tana i findina avalabla
The lav	Completed									autop perfor	sy	prior to c death?	topsy findings available ompletion of cause of
	ပိ	25 Was asso referred to medical							15 11	1 Tyes	2 No	1 🗆 Yes	2 No
	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	patient 2 🗆	EB/Outpotion	it 3 DOA	Other:	VIX.5		(Check only of		Other (Spec	()
ding Phys h. After this funeral di	 -	27. Manner of Death	28a. Date of		28b. Time of		. Injury a Work?			Bd. Describe h			iry)
nding th. :: Afte	atio	1 Natural 5 Pending 2 Accident investiga		, Day Year)	Injury	M		s 2 🗆 N	No				
for Attence after death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Place	of Injury - At he	ome, farm, str	eet, factory, o	office		28	Bf. Location (S	treet and	Number or Rui	ral Route Number,
s after al Dire	Cert	4 Northclas	Bulldin	g, etc. (<i>Specif</i>)	γ)					City or Tow	n, Siale)		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	dicai (29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the b xaminer: On the bas	pest of my kno	wledge, death	occurred at	the time,	, date and	d place, ar	nd due to the o	ause(s)	and manner as	stated.
ne F	Medi	one)	and manne	er stated.									
# 글 # 끝		29b. Signature and title of certifier))			29c. L	icense n	Iumber	7)	*		2. Of	ay. rear)
To the within To the Comp	1												
To the To the comp		Jan	kr hu	mul	no	1	101	550			τ,	1104	
To the comp		30. Name and a dress of person w Dr. John F. Fenwig				,	501	550	dreve	Wa		650	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** lance Reginald Α. Malone /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Prince George Lanham If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 1 Year Days 5. Social Security Number **Funeral** Hours Months 1⊠M 2□F 59 6,1945 June Director 578-58-3500 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County rai', or items 23a or 28e-f show Examiner must be notified at 1X Yes 2 □ No Springdale Director Md. Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20774 3808 Endicott Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify. Specify: Black Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) US.Postal Svcs Mail Handler 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be ပ Warren N. Malone Alvarese G. Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains 8808 Endicott Place Springdale, Md. 20774 Audrey Malone (Sister) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resurrection Cem April2,05 Clinton, Maryland Funeral Service Licen 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St NW ot enter the mode of dying, such as cardiat Approximate Interval Between 23a, Part 1. Egre the disease, or complice ed the death Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 Probably ieted peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2L NO enp XX No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be 2 No Hospital: Other: 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient 2 his 28d. Describe how injury occurred 27. Manner of D ath 28b. Time of 28c. Injury at Work? 28a. Date of Injury After Certification: Hospitel or Attending 124 hours after death. (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Thomicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year, 29c. License numbe 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who comp

MAR 3 1

2005

31. Date filed (Month

ted cause of death (Item 23a) (Type, Print)

	1	For State Registrar		aryland / Depa		Health and M		ne	1270
Physician		I. Decedent's Name (First, Middle, Las	0.				2. Date of Death Month	Day Year	3. Time of Death
/Medical		Felipe			rales		March 25,	2005	7:00 A M
Examiner	4	a. Facility Name (If not institution, give				or Location of Death		4c. County of Death	
		2320 Springdale 5. Social Security Number 6. Se		e (In yrs. last birthday)	If Under 1 Year	Valdorf	8 Date of Birth	Charle:	
rector			ум 2□ F	54 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye. 05/21/19		olace (State or Foreigr ntry) ⊇ma1a
Importent: If Item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic event, Item Medical Examples must be notified at once. To Be Completed by Funeral Director		Maryland Charles		10c. City, Town or Lo	ocation _dorf				10d. Inside City Limits 1 ☐ Yes 🍇 🙀 No
or 28e		0e. Street and Number	****		10f. Zip Code	20600	10g.	Citizen of What Cou	ntry?
in in	-	2320 Springdale I		5 I 40	141	20603	- 7 V	USA	
by Funeral Director		1. Marital Status 1 Never Married 2000 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify: Guat		14. Race - Americ Black, White, Specify: Hist	etc.
Completed	-	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4or f	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing 16b	. Kind of Business/In	dustry
treumatic event, the Mass To Be Comple		12th			Driver		7	<u>[ransporta</u>	ition
Be (7. Father's Name (First, Middle, Last)				_	e (First, Middle, Maid	•	
To To	L	Rodolfo Morales					a de Pieda	and the second s	
er treun		19a. Informant's Name/Relationship (T Guillermina Y. Moi		ife 2320	Springd	ale Ln. W	al Route Number, Cit aldorf, Ma		20603
50	2	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cree	sition (Name of matory or other pla	ce)	Date 20c.	Location - City or To	own, State
ci	-	* 4 □ Donation □ Other (Specify, 21. Signature of uneral Service, License	/	/ Kalas Cr		4/2/		gewater, M	
once		1 July by	alas N		160 Oxon	eorge P.	Kalas Fund d Oxon Hi	eral Home	P.A. 20745
an		23a. Pert1. Enter the disease, or mp show or heart failure. Lis only of Immediate Cause (Final disease or condition	lications thy caused ne cause in each li	the death. Do not ent				re, mo	Approximate Interval Between Onset and Death
al er ä		resulting in death) Sequentially list conditions, if any leading to immediate	MUC.	a consequence of): INDUS A a consequence of):	DENO	CARC	INDMA		
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mitiated events resulting in death) Last	с	a consequence of):					
is the burial-transit		(d						
y Physiclan/Med		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	4		23d. Date of delive Month	ery Day Year
P A	٠ '	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying cause giv	ren in Part I.		o use contribute to the	ne cause of death?
Completed	-	_				-	24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
rector, page		25. Was case referred to medical				26. Place of Death	1 Yes 2 XX	No 1 ☐ Yes	2□ No
To B		examiner? 1 ☐ Yes 2 🛣 No	Hospital:	ent 2 ER/Outpatien	at 3□ DQA Oth		me 5 ∑ ¥Residence	6 □Other (Specif	v)
e funeral atlon: T	1	27. Manner of Death 1 XIXI atural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28c. Injur Wor	y at k? Yes 2 □ No	28d. Describe how in		
Certification:		3 Suicide 6 Could not be determined	28e. Place of Injusting, et	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Street City or Town, Sta		l Route Number,
completely filled in by the funeral director. Medical Certification; To Be (29a. Certifier 12 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best ner: On the basis of and manner sta	of my knowledge, death f examination and/or in ated.	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as si and place, and due to	tated. the cause(s)
completely filled in by the Medical Certifical	-	29b. Signature and title of certifier MULLINN	win 1	ND	29c. Licens	10573	14 3	Date signed (Month,	Oay, Year)
	1	80. Name and address of person who c			Print) gron B1	vd # 34	10 FAICE	AX VA Z	22031
State	_	31. Date filed (Month, Day, Year) MAR 3 1 2005		ar's Signature					

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 3 1 2005 gistrar's Signatur

111 Penn Street

29c. License number

OCME

29d. Date signed (Month, Day, Year) March 27, 2005

Baltimore, Maryland 21201

ath (Item 23a) (Type, Print)

			i icase i	State of Maryland / D	constraint of Health	_			
			1 _ State	•	Certificate of Deal		Reg. No	2000	12700
-fe		-	Registrar 1. Decedent's Name (First, Middle, Last)			2. Date	of Death	- 40	3. Time of Death
	Physici: /Medic Examin	al	Henrietta Loui 4a. Fecility Name (If not institution, give :		4b. City, Town, or Location		ch 29,	2005 County of Deet	11:15A.M.
	ZX		5785 Washington	Ave.	La Plata		C	harles	
	Funeral Director		220-26-6777	The office	rs. If Under 1 Year If Under 1 Year Months Days Hour	rs Min. 8. Date (Mor	of Birth oth, Day, Year) r 18,19	9. Birth Cor 915 Mai	nplece (State or Foreign untry) Cyland
	/land		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Man e-f ah	ctor	MD Charles	La Pla	ıta				1 ☐ Yes 2½ ☐ No
	ith the	Director	10e. Street and Number		10f. Zip Code		10g. Cit	tizen of What Cou	untry?
	s 23a	eral	5785 Washington	AVE . 12. Was Decedent Ever in U.S.	20646	Origin? (Specify Voc	US	A 14. Race - Amer	ican Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28e-f ahow or other traumatic avant, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☎ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi		tc.)	Bleck, White	
21215-0036	2 hou	ted	15. Decedent's Edu	cation 16a.	Decedent's Usual Occupation	nost of working	16b. K	(ind of Business/l	
215	ithin 7 ne.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during n life. DO NOT use retired)	nost of working		_	
121	filed w Hygier thar th		17. Father's Name (First, Middle, Last)	Ho	memaker	other's Name (First, A		Iome	
and	Mental barked of	To Be	Henry Harry Hem	nglow		nrietta I		,	
Maryland	should and Men la marke sumatic	F	19a. Informant's Name/Relationship (Ty	The state of the s	Mailing Address (Street and Nur				ïp Code)
	1 and 2 Health a Iem 27 la		Hazel Wood/daug		39 Washingtor		a Plat	a, MD	20646
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State cemetery	Disposition (Name of crematory or other place)	Date		ocation - City or T	Fown, Stete
I I	permit. Pa Departmen Important: eny injury 9050.		* 4 □ Donation 5 □ Other (Specify)	Sacred	Heart Cem.				7 77
Ba	permit. Pages Department of I Important: If it eny injury or o		21. Signature of Funeral Service License	M00817	P.O. Box 567				eral Home
Œ			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do no				20040	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ue Heart	Failu	re		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as d consequence of					
100		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	Ŋ.				
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
,092	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a consequence of	f):				
6876	tificate b ig physic as the bi	dlcal		J					
9 x	eath certifi attending I for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy			1	23d. Date of deliv	/Arv
. Box	death e atter d for u	Physician/Med	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
P.0	that the de led by the a detached t	hys	9 Unknown	9□ Unknown					
Records,	The law requires that the death certifica ate has been signed by the attending phrage 2 should be detached for use as the	by	Part II. Other significant conditions con	itributing to death but not resulting in	the underlying cause given in Pa	art I. 23e		use contribute to	the cause of death?
ecc	law ra	Completed				24a	. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	t: The					10	performed? Yes 25 No	death?	2 🗆 No
Vita	siciar certif rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 Yo	lospital: 1 Inpatient 2 ER/Outp	Other	ace of Death Check	-	0 Flother (Con-	4.1
o	Attending Physician: r death. sctor: After this certification the funeral director, by the funeral director, it	n: To	27. Manner of Death	28a. Date of Injury 28b. Ti		Nursing Home 5-E 28d. Des	cribe how injur		iry)
Sior	ttendin death. ctor: Aft r the fun	atlo	1. Natural 5 Pending 2 Accident investigation	(Month, Day 1861)	M 1 Yes 2	□No			
Division of	l or Att after de Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office		ation (Street an or Town, State		ral Route Number,
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) CertifyIng Physical Examination (Check only one)	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date /or investigation, in my opinion, o	and place, and due to death occurred at the	to the cause(s)	and manner as:	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 1 00	29c. License numbe	er	29d. Daf	te signed (Month,	, Day, Year)
)			> forse	M Matter	0283	357	3/	130/01	
(D.		30. Name and address of person who co	mpleted cause of death (Item 23a) (T	Type, Print)	MA -	10/1	106	
-	DD6 Sta	•	31. Date filed (Month, Day, Year)	32. Registar's Signature	ericte	, 42 6	7 76	40	
	Registr		MAR 3 1	32. Regi kar's Signature	- Waren				

			1 - For State Registrar	State of Maryland	/ Department of I		ental Hygien	2000	i 2800
}	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last, SHADRACH 4a. Facility Name (If not institution, give SHADY GROVE		MUWANG 4b. City, Town, o OSP. ROCKV	UZI or Location of Death	APRIL &	ay Year 05 ZOOS c. County of Death	3. Time of Death 04,55AM
	Funeral Director		5. Social Security Number 6. Sex		Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year APR. OS, 2	9. Birthpl Count MAI	ace (State or Foreign try) RYLAND
	within 72 hours after death with the Maryland ene. Ithen "naturel", or Items 23e or 28e-f show he Madical Examiner must be notified at	rai Director	10a. State 10b. County	OMERY RO-	Town or Location ERMANTO 10f. Zip Code 2.0	UN, MA	RYLAND 10g. C	itizen of What Count	od. Inside City Limits 1 Yes 2 □ No iry?
900	172 hours after des "naturel", or Items allcal Examiner m	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
21215-0	be filed within 72 ho ntal Hygiene. od other then "natur event, the Medical	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of worki d)	ng 16b. (Kind of Business/Ind	ustry
a	Mer Mer atic	To Be (17. Father's Name (First, Middle, Last) MICHAEL 19a. Informant's Name/Relationship (Ty,	MUWAN		JOAN	(First, Middle, Maide	ARA	0-4-1
more,	Pages 1 an nent of Heal ent: If item 2 ury or other		MICHAEL MUWANG 20a. Method of Disposition 1 Burial 2 Cremation 3 BR 4 Donation 5 Other (Specify)	GUZI / FATHER 20b. Plac	19b. Mailing Address (Street 18322 TV) te of Disposition (Name of elery, crematory or other plain that the control of the cont	nko Lf	NE GERM ate 20c. L		MRYLAND vn, State
Balt	permit. Pag Department Importent: any injury o		21. Signature of Euler Service License	M	SGAH, 9	901 MED		UTER DR, 1	ROCKVILLE
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P.O. Box 68	death certif e attending id for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnancy	,		23d. Date of deliven Month	y Day Year
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аі несс	₹ 10 0	Completed					24a. Was an autopsy performed?	prior to come death?	sy findings available pletion of cause of
o v	Pnysicien: The la r this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No H	28a. Date of Injury 28	/Outpatient 3□ DOA Cth	4 🗀 Nursing Hoir	(Check only one) ie 5 ☐ Residence 8d. Describe how inju		
DIVISION OF VITAL RECORDS,	to the Hospite or Attending Fri within 24 Hours after death. To the Funerel Director: After th completely titled in by the funeral	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify)	Injury World	k? Yes 2 □ No	8f. Location (Street ar City or Town, State	nd Number or Rural I	Poute Number,
. د :	within 24 hours at To the Funerel D completely tilted in	edicai Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, death occurred at the tin and/or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause(s d at the time, date an) and manner as stat d place, and due to t	ed. he cause(s)
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10	B.M		30. Name and address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person who compared the same address of person	npleted cause of death (Item 23	HADY GROVE F	DUDUTIST, C			
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 4 20	32. legistrar's Signati	Come				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year PM Nettie Marshall Parks March 26 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Solomons Solomons Nursing Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 JF 74 Yrs. 216-28-9618 Maryland Dec 7 1930 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Broomes Island Maryland Calvert 1 TYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20615 4047 Nans Cove Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married white 1 Yes 2 KNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nettie B. Joy John A. Railey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel M. Parks- husband 4047 Nans Cove Road Broomes Island MD. 20615 Cometery, crematory or other place) March 30 Pate 2005 Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Alexandria Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 20676 4405 Broomes Is. Rd. Port Republic MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythmia. Cardiac 5 minules disease or condition resulting in death) Due to (or as a consequence of) Cardio Vascular disease Athero scieno ha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4 Pregnant at time of death 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellitus Requiring 1 Yes 2 No 3 Probably 4 Monknown Renal insubbicient cerebro vosculor Accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

itam 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Exertains requisites an other seconds.

Hygiene.

Pages 1 and 2 should be filad nent of Health and Mental Hygis int: If itam 27 Is marked other

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Department of Important: If any injury or once.

Completed by Funeral Director

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death

filad within 72 hours after

Baltimore, Maryland 21215-0036

the burial-transit director.

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After !

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Hospital 24 hours a

or Attanding Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Physician/Medicai Examiner þ Be Completed filled in by

Certification: To Medicai

29a. Certifier

IF FEMALE: 25. Was case referred to medical 27. Manner of Death

examiner

1 Natural

3 Suicide

2 Accident

4 Homicide

(Check only one)

1 Yes 2 No

5 Pending

investigation

6 Could not be determined

State

Registrar

5851 -Deale 31. Date filed (Month, Day, Year) MAR 3 1 2005

29b. Signature and title of certifier

wona. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) churchton

28a. Date of Injury (Month, Day Year)

D. 50653.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

3-28-2005.

GYAN - C. SURANA.

Deale

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death Check onl one

2 No

28d. Describe how injury occurred

Road -32. Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Janet Reginato 05-2275 AKG

			For State Registrer	State of M	Maryland		artment of F tificate of			ental Hy	giene Reg. No	DANE	12802
	Physici	an	1. Decedent's Name (First, Middle			301				2. Date of De	ath Day	y Year	3. Time of Death
	/Medic Examir		Janet Ann Re	, give street and number	or)		4b. City, Town, o			March		2005 County of Death	L_6:35 A™
	Funeral Director		45690 Corporate 5. Social Security Number 087-66-5096		Age (In yrs. Ia	st birthday) Yrs.	Lexingt If Under 1 Year Months Days			8. Date of Bir (Month, Da	rth ay, Year)	9. Birtho	ary's County blace (State or Foreign bry) York
			Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation			0 10 1			Od. Inside City Limits
	r 28a-f sh	Director	MD St. Ma	ry's	Great	t Mill	.S 10f. Zip Code				10g. Cit.	izen of What Cour	1 □ Yes 2 425No
	eath with	Funeral D	45642 Jillian	Court 12. Was Decede	nt Ever in II S	13 1	20634 Was Decedent of H	lispanio ()	rigin? (Spec	oify You or N		ed State	
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21215-0036	e * 8	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education it grade completed) College (1-4c	or 5+)	(Give life. l	lent's Usual Occup kind of work done DO NOT use retired	durina mo	st of workin	g		ind of Business/Ind	dustry
	be filed within tal Hygiene. d other than event, It.e M	Be Co	17. Father's Name (First, Middle,	Last)		_Manag	ger	18. M oth	ner's Name	(First, Middle		Staurant Sumame)	
Maryland	2 should be for and Mental I is marked of raumatic eve	2	Mark R. Drummon			19b. Mailir	a Address (Street			nerese		or Town, State, Zip	Code) 20619
, Ma	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Mark Drummond/		an Di	23140	Cobbles		Lane,	Apt.	310,	, Califor	nia, MD
Baltimore,	permit. Pages 1 and 2 Department of Health e Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	te cei	metery, cren	sition (Name of natory or other place of checked by a constant)	1	4-4-2	2005		erlotte H	
Ball	permit Depar Impor any in		21. Signature of Funeral Service Edvard N. Brins:	ield Jr. 1	M00052	22		ywood	l Road	Leor	nardt	uneral Ho cown, MD	
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_			30. Name and address of person	Aronica-	Follo	KM		nn St	reet	Balti	more	, Maryla	nd 21201
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			1- For State of Maryland	-	artment of I		ind Me	ental Hy	giene Reg. No	2005	12803
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	/Medic	al	Charles Arthur Reid 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of		March		County of Death	7:14 P M
	Examin	er	Washington Adventist Hospital		Tako					rince Ge	
	Funeral Director		5. Social Security Number 237–36–4649 Usual Residence of Decedent	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Bi Month, D.	1930	9. Birth Cou N • C	place (State or Foreign Intry) Carolina
	yland Jow			Town or Lo	cation						10d. Inside City Limits
	e Man	ctor	MD P.G. E	owie							1 ☐ Yes X☐ No
	with th	Funeral Director	10e. Street and Number 4117 Crosswick Turn		10f. Zip Code 207	15			•	zen of What Cou	entry?
	ns 23	erai	11. Marital Status 12. Was Decedent Ever in U.S.	. 13. V			in? (Speci	ifv Yes or No		14. Race - Ameri	can Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other traumatic event, It a Modical Examination use to multiply alonge.	by Fun	Armed Forces? 1 Never Married 200 Married 1 Yes 2 In No If Yes, Give A year or Dates:	li li	Vas Decedent of I Yes, specify Cub ☐ Yes 2/2 No		Puèrto Ri	ican, etc.)		Black, White	
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	/Medic Examin		4a. Facility Name (If not institution	give street and nu	mber)		4b. City, To	own, or	Location o	f Death		4c	. County of De		
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	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔏 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months 1	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 11-15	th y, Year)	9. B	inthplace (State Country) W Jer:	or Foreign
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Š	w require been si	ete									24a, Was	20	24h Were	autopsy finding	is available
Records,	The lay	Completed						· · · · · · · · · · · · · · · · · · ·			auto	psy ormed?	prior to death?	completion of	cause of
		0	25. Was case referred to medical			-			26. Place	of Death	1 Yes		1 UY6	s 2 No	
of Vital	ysicie is cer direct	8 0	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Cthe					6 □Other (Sp	pecify)	
0	ding Ph h. After thi funeral	n: To	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date (Mor.	of Injury oth, Day Year)	28b. Time o	f 280	c. Injury Work	at ?		8d. Describe				
<u> </u>	Attending Physicien: or death. ector: After this certifically the funeral director.	catle	2 Accident investig	gation			М	1 🗆 Y	'es 2 □!						
Division	i ir te	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Place	e of Injury - At h ing, etc. <i>(Speci</i>	iome, farm, sti fy)	eet, factory,	office		2	18f. Location (City or To		nd Number or i e)	Rural Route No	ımber,
	To the Hospitel within 24 hours e To the Funerel Completely filled		29a. Certifier 1X Certifyin	g Physician: To the	a bast of my kn	owladna daat	h occurred at	t the tim	a data an	d place, a	nd due to the	causole) and manner	as stated	
	To the Hospital within 24 hours e To the Funeral I completely filled	edical	(Check only 2 Medical one)	Examiner: On the b	easis of examination	ation and/or in	vestigation, is	n my op	inion, deal	th occurre	ed at the time,	date an	d place, and di	ue to the cause	9(s)
	To the	Me	29b. Signature and title of certifie		2		29c.	License	number			29d. Da	te signed (Moi	nth, Day, Year,)
) /<	en (_		1,	Do	0537	03		3	1281	05	
K	2/8)		30. Name and address of remn	who completed cau	se of death (Ite	m 23a) (Type,	Print)			1	1	4.4	1281	0-	
1	0		TSION BERHANE	MD	3001	HOSPIT	AL D	KIVE		CHE	EVERLY	141	2071	00	
	Sta Registi		MAR 3 1 20	05	Registrar's Sign	ature	1.5								
	riegisti	211	IIIVII O T CO			MILES									

				State of Marylar				-		egible.	
			1 - Stata Registrar			rtificate of		•	Reg. No	005	12805
	Physici	an	1. Decedent's Name (First, Middle, Last)		-			2. Date of Dea	ath Day	Year	3. Time of Death
	/Media	al	Ozell Richmon 4a. Facility Name (If not institution, give s			Ab Cib. Tours	al anation of Dan	March	1	2005	6:15A.M
	Examin	9	2007 Oglethorpe			4b. City, Town, o	141	ıtn		ounty of Death	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr		h	nce Ge	place (State or Foreign
	Director		371-38-1636 1X. Usual Residence of Decedent	^{1M 2□ F} 64	Yrs.	Months Days	Tiours Will	April2			sissippi
	yland now		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	e Mar	ctor	Md. Prince G	eorge Hya	ttsvi	lle -					1XYes 2 No
	with th	Director	10e. Street and Number			10f. Zip Code			_	n of What Cou	ntry?
	eath v	Funeral	2007 Oglethorpe	St.#303 12. Was Decedent Ever in U	IS 13	20782	isnanic Origin? (Specify Ves or No.	USA	Race - Americ	can Indian
9	after d	Fun	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give		Was Decedent of H		nto Rican, etc.)		Black, White,	etc.
003	d within 72 hours after death with the Maryland jiene. Ir than "natural", or Items 23e or 28e-f show The Medical Examination matter collised at	d by	3 ☐ Widowed 4 💆 Divorced	Year or Dates:		1 ☐ Yes 2 No	Specify:		Sį	pecify: Bla	ıck
15-	n 72 ł	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	orking	16b. Kind	of Business/In	dustry
212	d within giene. Ir than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+) Yrs	Poli		•/		Metr	o Poli	ce Dept
Maryland 21215-0036	othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,			-
yla	should bud Menta	Jo	Lester Richmond					y Gilli			
Mai	2 m m m		19a. Informant's Name/Relationship (Type			ng Address (Street					
	of Health item 27 other tr		Darryl Richmond 20a. Method of Disposition	20b.	Place of Dispo	Mass Av sition (Name of matory or other place		F112U W.		DC 200 tion - City or To	
<u>m</u>	Pages nent of I ont: If it		1 X Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	ction Ce	1	i102,0	CII	nton	- 5M
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Savice License			2. Name and Addre		Wash,			
	7 □ = 6 0		23a. Part1. Prier the disease, or condi	your		rone J. ter the mode of dyin				9 Kenn	edy St.NW
	De .		23a. Part1. Ther the disease, or condi- shock, of heart failure. List only on Immediate Cause (Final	e cause of each line.	U	ter the made of dyin	g, such as cardia	ic or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	. Hypertens Due to (or as a consec						-	
E	Examiner		Sequentially list conditions	Hyperchole		olemia					
10	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):						
_6	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					-	
760,	w ~ ~ ~	cai	C	1.							
89	leath certificat attending phy I for use as th	edi	IF FEMALE:								
Вох	death certifica e attending ph d for use as th	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1☐Live birth 2☐Feta	al death 3	Ectopic pregnancy			230	d. Date of delive Month	ery Day Year
o.	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□ Unknown	Jeath 5L	Other (specify)					,
S, D	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	he cause of death?
ord	w require been sig should b	ted t						1□Y	es 2🗓 l	No 3 ☐ Prob	pably 4 Unknown
Record	aw as b	ompleted						24a. Was autop	sy	prior to cor	psy findings available mpletion of cause of
al H	n: The icate har.	O						perfor 1 ☐ Yes		death?	2 No
Vital	Physicien: T this certificate al director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 👿 No	lospital: 1 Inpatient 2	TER/Outpotion	oth		ath (Check only of		7011 10 1	,
٥٥		H	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injun	/ at	Home 5 X Resid			0
sior	Attending r death. sctor: After by the fune	catlo	1 XNatural 5 Pending 2 Accident investigation	(Monin, Day Taur)	Injury	M 1	Yes 2 □ No				
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, sti fy)	reet, factory, office		28f. Location (S City or Tow	treet and N n, State)	lumber or Rura	I Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in		29a. Certifier 1 X Certifying Phys	sician: To the best of my kno	owiedge, deat	h occurred at the tin	ne, date and plac	e, and due to the o	ause(s) an	d manner as st	tated
	ths Horin 24 h the Fur	edical	(Check only 2 Medical Examinations)	ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death occ	urred at the time, o	late and pla	ace, and due to	the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier	2	-	29c. License	e number	- 2	29d. Date	igned (Monfn,	Day, Year)
, ,	7		112	-0	Mp		5075	•	>/:	2910	2005
_	(19)		30. Name and address of person who co					T	1 .		0.770
	y Sta	ate	Bernard Farzin, 31. Date filed (Month, Day, Year)			vay Cent	er Dr.	rs Gree	nbel	t,MD 2	.0770
1	Registi	ar	MAR 3 1 2005	2. Hegistrar's Sign	1900						

			For State		State o	f Maryla	and / De	partme <i>ertifica</i>				ental Hy		2000	`	12006
			Registrar 1. Decedent's Nam	ne (First, Middle	Last)			Crunca	10 01	Death		2. Date of D	Reg. N	a U U U	,	3. Time of Death
	Physici	an	_								1	Month	D	ay Ye	ar	S. Time of Death
	/Medio		Francis		ide Ric , give street and nur			4h Cih	Tour	or Location of		MARCH		2005 c. County of D		11:00 A ""
	Examir	er			-	no o i)		40. City	, TOWII, O	or Location C	oi Deatii		1 *	c. County of D	eath	
			5. Social Security I		L CENTER 6. Sex	7 Age //n u	rs. last birthda		APLAT er 1 Year	ΓA If Under:	24 Hrs	8. Date of B	inth	CHARLE	S	
	Funeral		-		172 M 2□F	89	Yrs. Vast birtinos	Months		Hours	Min.	(Month, D	Day, Year	7) 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		ce (State or Foreign y)
	Director		217-05- Usual Residence of			09			1		Ψ	ct.12	2,19	915 Ma	ryl	and
	land ow		10a. State	10b. County		10c.	City, Town or	Location							100	d. Inside City Limits
	Mary Hish	ŏ	MD	Charl	AC	Tr	ndian	Tood.								1 ☐ Yes 2X No
	the 286	Director	10e. Street and Nu			111	iuran		ip Code				10g. C	itizen of What	Countr	v?
	death with the Maryland rms 23e or 28e-1 show	Ö	20 0:	1. 1. 1.					2064	. 0						, .
	ns 2;	Funerai	30 Circ	Te Ave	12. Was Dece	edent Ever in	n U.S. 1				gin? (Spec	cify Yes or N		JSA 14. Race - A	mericar	ı Indian.
10	or iter	F		ried 2 Marr	Armed Fo	rces? 2 □ No		If Yes, sp	ecity Cub	an, Mexican	i, Puerto R	tican, etc.)		Black, W	vhite, et	c.
936	urs a	by	3 XWidowed	4 Divorced	ied 1 17 Yes If Yes, Gir Year or D	ve lates: 194	4.5	1 🗆 Yes	28C No	Specify:				Specify:	hit	. 6
No	etur	Completed		15. Decedent	's Education	<u> </u>	16a. De	cedent's Us	ual Occup	oation			16b.	Kind of Busine		
75	nin 7	pie	(Spe Elementary/Sec		t grade completed) College (1-4or 5+)	(G.	ive kind of w e. DO NOT	ork done use retire	du <i>ring mos</i> d)	t of workin	g				
25	d with	mo:	11	oridary (o .z/	Conago (1 401 517		Mech	anic				Fed	leral	Gov	ernment
g	othe	w	17. Father's Name	(First, Middle,	Last)						er's Name	(First, Middle				
<u>a</u> CV	fental fental rked tic ev	To B	Francis	Claud	le Rice					Anna	Cat	herir	a L		r	
SE S	shou ind A		19a. Informant's N				19b. Ma	ailing Addres	ss (Street					or Town, Stat		°ode)
PAAMC/S RICE Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel; or items 23e or 28e-1 show any injury or other treumetic event, the Macinal Examination and bance. and the standard of the treumetic event, the Macinal Examination of the restriction of the standard and the standard of t		Gail Du	itton/N	Niece		950	1 Car	narv	Dri	ve B	e1A1t	ton	MD 20	611	
ďδį	f Her f Her item othe	1	20a. Method of Dis	sposition			b. Place of Dis	sposition (Na crematory or	ame of		Da	ate		Location - City		n, State
(Z.E	Page ent o nt: if ry or		1 ⊠Burial 2 `4 □Donation		3 □Removal from		t.Igna	-		. 4	/2/2	005	Dox	+ Tob		a MD
7	permit. Page Department importent: if eny injury o	Н	21. Signature of F				c · rgiic					ort-F	Cho	t Tob	non	al Home
ñ	permi Depar impor eny ir		19 an	1 2	185 7	77	b							2064		ar nome
			23a. Part . Enter	he disease, or	complications that	aused the d								2004	A	Approximate
			shock, or he Immediate Cause		only one cause on e	each line.	<i>a</i> /	AN	75	0					h	nterval Between Onset and Death
	Physician /Medical		disease or conditi resulting in death)		a. Dua to	UNC	sequence of):	3114	u	./					110	N Monty
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89	ficate g physics the	edic														
Вох	death certifi e attending id for use as	N/M	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, ou			_						23d. Date of	delivery	
ă	seath atte	cia	in the past 12	2 months?		oirth 2 □ F nant at time (3 □Ectopic _I 5 □ Other <i>(s</i>		y 				Month	,	ay Year
0	the or	Physician/M	9 □ Unknow		9□ Unkn	own										
σ.	requires that the de een signed by the a nould be detached t	by P	Part II. Other sign	ificant condition	ons contributing to d	eath but not	resulting in the	e underlying	cause giv	en in Part I.		23e. Did	tobacco	use contribut	e to the	cause of death?
ds	puires n sign ald be											1 🗆	Yes 2	2 □ No 3 🔀	Probat	oly 4 □Unknown
<u> </u>	> 0 0	Completed										24a. Wa	e an	24h Were	autons	y findings available
Re	The taw ite has b	m										auto	opsy formed?	prior	to come	eletion of cause of
7	n: Th ficate r, pa											1 ☐ Yes	2 X N	0 1 1	res 2	□No
Division of Vital Records,	Physicien: The tribic tribic tribic certificate har all director, page	Be	25. Was case reference examiner?		Hannitals 1	A ²			Ott			(Check only				
of		₽:	1 Yes 2	⊈ No	1 1		2 ER/Outpa 28b. Time		NOA	4 🔲 140	-			6 Other (Surv occurred	Specify)	
L C	Attending F r death. ector: After by the funera	tion	Natural	5 Pendin		of Injury th, Day Year	r) Injur	У	28c. Injui Wor	rk? Yes 2⊟i		od. Doscribe	o now my	ury occurred		
isi	death. ctor: A y the fu	ica	2 Accident 3 Suicide	6 Could	not be	of Injury - 4	At home, farm,			100 20		8f Location	(Street a	and Number or	- Aural F	Route Number
S	or A after Dire	Certification:	4 Homicide	determ	build	ing, etc. (Sp	pecify)	Street, racto	rry, orrice			City or To			7107077	iodia i vainoai,
	pitel ours erei filled		29a. Certifier	1 X Cartifuin	g Physician: To the	host of my	kaawladga di	noth coours	d at the ti	mo doto oo	d place of	ad due to the		-\		
	Hos 24 h Fun Hely	Medicai	(Check only one)	2 Medical	Examiner: On the b	easis of examiner stated.	nination and/o	r investigatio	n, in my	opinion, dea	ith occurre	d at the time	, date ar	nd place, and	due to th	ne cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Mec	29b. Signature an	d title of certifie	/	stateu.		25	9c. Licens	se number		1	29d. D	ate signed (M	onth. Da	av. Year)
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	Sta	ate	J. Date med [MO	MAD		legi far's Si		dos	Je J							

			1 - For State Registrar	State of Mary		epartmer Certificat			nd Men	tal Hygier	2001	5 280	to de la constitución de la cons
	Dhysiai		Decedent's Name (First, Middle, La.	st)						ate of Death	Day Yea	3. Time of Death	7
	Physici /Medic		Jack_C. Shatze							ril 2	2005		1
	Examin	ner	4a. Facility Name (If not institution, give			4b. City,		Location of			4c. County of De		
			Homewood Retire 5. Social Security Number 6. S		yrs. last birth	day) if Unde	Wil 1 Year	liams If Under 24		late of Birth		shington	
	Funeral Director			X M 2□F		Months	Days	Hours	Min. (A	n. 16, 19		Birthplace (State or Foreig Country)	П
PC			Usual Residence of Decedent	1.2						111.10,13	21 16	nnsylvania	
arylar	show	<u>_</u>	10a. State 10b. County		c. City, Town							10d. Inside City Limits	
he M	28e-f	ectc	Maryland Washi	ngton	V	/illiams		-	· · · · · · · · · · · · · · · · · · ·	400	000000000000000000000000000000000000000		_
with	l be	ā				10f. Zip		1705		109.1	Citizen of What		
death	me 2:	Funeral Director	16505 Virginia Av	12. Was Decedent Ever	in U.S.	13. Was Dece		21795 spanic Origi	in? (Specify)	Yes or No-		USA mencan Indian,	_
after	or its		1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No	1942-	If Yes, spe		n, Mexican, Specify:	Puerto Ricar	n, etc.)	Black, W	hite, etc.	
3-UUSO 72 hours after death with the Maryland	giene r than "natural", or itame 23a or 28e-f show the Medical Examinar must be notified at	d by	3 ₩idowed 4 □ Divorced	If Yes, Give Year or Dates:	1945							White	
n 72 I	"nat edica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. [Decedent's Usu Give kind of wo life. DO NOT u	al Occupa rk done d	ation <i>furing</i> most o	of working	16b.	Kind of Busine	ss/Industry	
within	than the M	omo	Elementary/Secondary (0-12)	College (1-4or 5+)			pent				General	Construction	or
	ent,	BeC	17. Father's Name (First, Middle, Last)				FULL		s Name (Firs	st, Middle, Maid		3011311 40111	
uld be		To B	Richard Shatzer					Rutl	h Reed	er			
Mar d 2 sho	and Is me		19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Address	(Street a	ind Number	or Rural Rou	ite Number, Cit	y or Town, State	, Zip Code)	
	nt of Health and Men If Item 27 Is marke or other treumatic		Judy Lipski-Daug	hter	15	309 Wir	ches	ter Re		saptown		502	
MOT Pages	Department of Heal important: If item 2 any injury or other once.		20a. Method of Disposition 1 XBurial 2 Cremation 3	THEITIOVALITOITI STATE		Disposition (Nar crematory or o			Date		Location - City		
altimor	Departmen Important: any injury once.		'4 □Donation 5 □ Other (Specify 21 Signature of Funeral Service Liften		nion C	emetery					lford,Pe	nnsylvania	
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			23a. Parti. Enter the disease, or com	plications that caused the	death. Do no						Tallispoi	Approximate	_
Ph	ysician		shock, or heart failure. List only		11.05	1	1.		P	-52 1		Interval Between Onset and Death	
/1	Medical		disease or condition resulting in death)	Due to (or as a co		FAW6	nor	72,	Vear	rrent		4 months	_
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ate be e	ohysician and the burial-transit	dicai E	· ·			,.							
The law requires that the death certificate	g phys as the	O I		d									
5 5	use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		200-1-1-1	0.00				23d. Date of o	lelivery	
deat	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		3 ⊟Ectopic pr 5 ⊟ Other (sp					Month	Day Year	
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, se	signed be d	by	Part II. Other significant conditions of	4 4	t resulting in t	he underlying c	ause give	n in Part I.	2			to the cause of death?	
w requires	hould	Completed	Diabetes Mel		,				_	1 🗆 Yes		Probably 4 Unknown	
e aw	has t	mpi	Atheroscleratic	Heart Dis	ease				2	4a. Was an autopsy performed?	24b. Were prior to death	autopsy findings available completion of cause of	1
VILCIEN: Th	ficate r, pag		05.116							Yes 2004			_
Sicie	certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 EB/Outs	atient 3 DC	Othe		of Death (Che		0. 1704 (5.		_
VISION OF	eral d	H	27. Manner of Death	28a. Date of Injury	28b. Tir		8c. Injury Work			Describe how in	6 □Other (Sp jury occurred	өспу)	
<u> </u>	ath. or: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Inji	M		es 2 □No					
Y Atte	irecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)		n, street, factory	, office			ocation (Street		Rural Route Number,	
J ele	urs af rei D												
To the Hospitel or Attending Physicien:	within 24 hours after death. To the Furset Director. After this certificate has been signed by the attending pi To the Furset Director. After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use as t	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exa- and manner stated.	knowledge, mination and/	death occurred or investigation	at the time in my opi	e, date and p inion, death	place, and du occurred at t	ue to the cause the time, date a	(s) and manner and did and place, and di	as stated. ue to the cause(s)	
o the	omple	Med	29b. Signature and title of certifier	and manner stated.		290	. License	number		29d. E	Date signed (Moi	nth, Day, Year)	
-	> - 0		Cynthia Ku	ther San	do my	D	474	51			ril 3, 2		
			30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Print) A	1510	a Han	ne 1	6505	Virgini	a Avenue	_
H-13	5+1		30. Name and address of person who of Cynthia Kuthner	Sands, MD	Homeu)00 Q /Y	~ ~ ~ ~ ~	J	Willia	MSPOF.	+ Mary	land 21795	
	Sta Registr	9	31. Date filed (Month, Day, Year)	32. Ragistrar's S	Signature	Ang. H.	1			•	, ,		

			1 State	eartment of Health and Ment	al Hygier	0000	10000
			1. Decedent's Name (First, Middle, Last)	2. D	ate of Death	ليا-ليا ليا سا	3. Time of Death
	Physici /Medic		MARSHALL SN	Mar Mar	ch 31	, 2005 ar	800 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			12602 Spickler Road	Clear Spring If Under 1 Year If Under 24 Hrs. 8, Di	- 1 - (B' 1)	Washing	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 214-34-0642 7. Age (In yrs. last birthday 7. Security Number 68 7. Age (In yrs. last birthday	Months Days Hours Min. JUN	ate of Birth Month, Bay, Yes I e 9, 19	9. Birthp	place (State or Foreign otry) yland
			Usual Residence of Decedent			1141	y zana
	nrylan show	_	10a. State 10b. County 10c. City, Town or L			1	0d. Inside City Limits 1 ☐ Yes 2 XXNo
	Ba-f	Director		Spring	40-	200	
	with t	Dir	10e. Street and Number 12602 Spickler Road	10f. Zip Code 21722	10g. (Citizen of What Cour	itry?
	n 72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show salism Exacting the notified at	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican	es or No-	14. Race - Amend	
٥	or Ite	Fur	1 Never Married 2 Narried Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2 ☐ XNo Specify:	ı, etc.)	Black, White,	
12-0036	hours after turel', or Ite	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: Wh	
2	within 72 h ene. then "net	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Inc	dustry
7	withi iene r then	шо	Elementary/Secondary (0-12) College (1-4or 5+)	ner and Operator		Bar	
and	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs	t, Middle, Maid	en Sumame)	
Z		To	Earl Leon Small	Naomi		Hawba	aker
Mar	d 2 should th and Mer ?7 Is marke traumatic			ling Address (Street and Number or Rural Rou			
	s 1 and of Health item 27 other to		20a Method of Disposition 20b. Place of Disp	2 Spickler Road, Clea:		g, Maryla Location - City or To	
nor	0 0 = =		1 Rurial 2 Cremation 3 Removal from State	own Crematory 04-02-			
saltimore,				-		gerstown,	Mary rand
ñ	permit. Departr Import		R. hall Brady	Andrew K. Collman Fun 40 East Antietam Stre	eral Ho et. Hac	ome, Inc. Derstown	Md. 21740
li			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Officers)	atic Cardiovaso	cular	disease	200 ears
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	Examine:	7	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted J Insit	Examine	cause. Enter Underlying Cause (Disease or injury				
'n.	exection and rial-tra		that initiated events c				
9/8	certificate be executed nding physician and use as the burial-transit	dicai					
Ŏ	entifica ling pl	Med	IF FEMALE:				
X Q Q	ath	Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
o.	0 0 0	nysic	1 Yes 2 No 9 Unknown	□ Other (specify)			
7	requires that the de leen signed by the a hould be detached f	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	3e. Did tobaco	o use contribute to th	ne cause of death?
rds	w require been sig should b	ed b			1 🗆 Yes	2 3 □ Prob	ably 4 Unknown
ecord	- Q (n	Completed		2	4a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
r	The ate h page	Con		1	performed?	death?	2□ No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Che	ock only one)		
O	hys his	5	1	AIL 3 DOX 4 INDISING HOME	Residence Describe how in	6 ☐ Other (Specify	/)
O	nding th. : Afte	ttlon	TANatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No		,,	
DIVISION	el or Attending P s after death. il Director: After t d in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Lc	ocation (Street lity or Town, Sta	and Number or Rura	l Route Number,
ב	tel or rs afte el Dir led in	Cert	Building, etc. (Specify)		ny 01 70m4 01		
	os, ital 4 hours a uneral D	edical	29a. Certifier (Check only Check only (Check only Check only C	ith occurred at the time, date and place, and di nvestigation, in my opinion, death occurred at t	ue to the cause the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	To the oswithin 24 h To the ur	Med	one) and manner stated. 29b. Signature and the of certifier	29c. License number	29d. [Date signed (Month,	Day, Year)
	2 3 2 8		1 / Long (No. no long)	DUD DODISSOI	A	201/1	2005
			30. Name and address of person who completed gause of death (Item 23a) (Type), Print)	1 14	, ,	1
ВН	-5			cal Campus Road, Hage	rstown,	Maryland	21740
	Sta Registi		31. Date filed (Month, Pay, Year) 2005 32. Registrar's Signature	beck			

	•	For State Registrar	State of M		•		of H	ealth ar		ntal Hyg	jiene	005	12809
Physici	an	Decedent's Name (First, Middle, Last Daniel M. Stoltz:								Date of Dea Month	th Day	Yeer 2005	3. Time of Death 2:01 p
/Medic Examin		4a. Facility Name (If not institution, give	street and number)			own, or	Location of		KLL		County of Death	
Funeral Director		5. Social Security Number 6. S 219-36-9897		ge (In yrs. la		If Under 1		If Under 24	Min.	Date of Birth (Month, Day ct 14,	Year)	9. Birth	hplace (State or Foreign untry) sylvania
death with the Maryland rms 23e or 28e-f ehow rr ust be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mary	's		, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2X No
with the	Director	10e. Street and Number 37541 Grove Farm Lane				10f. Zip (Code 1659				10g. Citiz US	en of What Co	untry?
IIIQ X IX 13-UU30 be filed within 72 hours after death with the Marylar lial Hygiene. Id other than "natural", or items 23e or 28a-1 ahow event, the Medical Examinatr ast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? [No	ì		ent of Hi ify Cuba		in? (Specify Puerto Rica	/ Yes or No- an, etc.)	1	4. Race - Ame Black, White Specify: Whi	e, etc.
within 72 hours after ene. then "neturel", or ite	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade <i>completed)</i> College (1-4or	5+)	(Give life.	DO NOT use	k done a	luring most o	of working			d of Business/	Industry
id III Z I Z I	Be	7 17. Father's Name (First, Middle, Last, Elam D. Stoltzfus)		Labore	r			's Name (Fi	irst, Middle,		W Mill Sumame)	
re, Iniaryian s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	2	19a. Informant's Name/Relationship (Sarah S. Stoltzfus/Wi				_		and Number	or Rural Ro	oute Numbe		Town, State, 2	Zip Code)
0 8 2 = 5		20a. Method of Disposition 1 ABurial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	9	lace of Dispo emetery, crea her Cem		e of her plac	- 1	Date oril 7,			ation - City or	Town, State e, Maryland
Dalling permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Lice	ra Dar	D	P	. О. Во	x 27		ardtow	n, Mary	land	ner Fune 20650	ral Home, P.A.
Physician		23a. Part1. Enter the disease, o com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications the cause one cluse on each Acute	ed the feath line.	Cord	ter the mode	of dying	g, such as c	ardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death
/Medical Examiner	Jer.	- 1	a. Acute Due to (or a b. Due to (or a	is a consequ	uanca oi, 1		//	~					Zishs Ymes
BOX 68/600, auth certificate be executed attending physician and for use as the burial-transit	cal Examiner	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Cord Due to (or a	MC is a con Aqu	Av. uence of):	ruy 1	Dv.	retri					y sies.
. 5 00	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal at time of de	Ideath 3	⊒Ectopic pre ⊒ Other (spe					2	3d. Date of del Month	ivery Day Year
that the sed by detail	by	Part II. Other significant conditions	contributing to death	but not resi	ulting in the u	underlying ca	ause give	en in Part I.		23e. Did to	4.0	12.1	the cause of death?
	Completed									24a. Was autop perfor 1 Yes		24b. Were au prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
On or vital r ding Physicien: Th n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Natural 5 Pending			ER/Outpatie 28b. Time of Injury	_	8c. injun Wor	er: 4 🗆 Nur:	sing Home 28d	5 Resid	dence 6	i □Other (Spe r occurred	city)
Sic tent tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of I	Injury - At ho etc. (Specif	ome, farm, st			703 2 310	-	Location (5 City or Tox			ural Route Number,
UIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysicien: To the be miner: On the basis and manner	of examina	owledge, deal	th occurred anvestigation.	at the tin	ne, date and pinion, death	d place, and h occurred	due to the at the time,	cause(s) date and	and manner as place, and due	s stated. a to the cause(s)
To the l	Me	29b. Signature and title of certifier	-	>		290	_	150	27			signed (Mont	
2		30 Name and address of person who	PO BOX 18	6 MEC	HANICS	SVILLE	. MI). 2	20659				
St Regist	ate trar	31. Date filed (Month, Day Year)	6 2005 Regis	selr's Signa	ature #	Sur	N						

DHMH 17 Rev 1/2001

DANIEL M STOLTFUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 26, 2005 4c. County of Death Marian Mildred Sheppard March 11:00pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Hours 1 M 2 T Months Director May 15, 1924 579 66 2220 80 Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Modical Examiner rougher conflied at 1 ☐ Yes 2 ☐ No Director MD Silver Spring Mantagmery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3210 N. Leisure World Blvd., #211 20906 United States of America Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. Int: If itam 27 Is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) 12th 4years Teacher DC Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Devitt Summers Grace Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne Sheppard Daughter 3107 River Bend Ct., E304 Laurel, Maryland 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) ö permit. Page Department of Important: If any injury or once. Lincoln Memorial Cemetery | 04/02/2005 Suitland, Maryland 22. Name and Address of Facility John T. Rhines Funeral Home 21. Sur ture of uneral Service License 3015 12th Street, NE Washington, DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Trace Metabolic Freeholquthy/ Urania Due to (or as a consequence of): 4 days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Renal Failure
Due to (or as a consequence of): 4 days Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) 4 days Physician/Medical Infected Decibitio Ulcers 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Urosepsis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Pulmonary Edema autopsy performed? 1□ Yes 2⊋No Paneytiponia Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🙀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical npletely (Check only 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier **4786**7 March 27, 2005 30. Name and add who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Oney Zuniga, North, Day

APR 0 1 2005

SHEPPARD , MARIAN

2. Registrar's Signature

70

		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day	Year 3. Time of D
Physiciai /Medica		Clarence Edward	Simms, Sr.				April 2	2005	05:59
Examine		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	or Location of Dea		4c. County	of Death
		Southern Maryland I			Clint				e George's
Funeral Director		5. Social Security Number 6. Sex 1X	M 2□F 45	yrs. last birthday, Yrs.	Months Days	If Under 24 Hr. Hours Min	. (Month, Day,	Year)	Birthplace (State or F Country)
JII ector	1	Usual Residence of Decedent	15				Oct. 26	, 1959	Maryland
Mow E		10a. State 10b. County		. City, Town or L	ocation				10d. Inside City
Sa-1 s	cto	MD Prince Ge	eorge	Clintor	1				1 (X)Yes 2
I health and Mental Hygiene. item 27 is marked other then "naturel", or items 23s or 28s-1 show other treumetic event, I'm Medical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code 2073	25	1	0g. Citizen of W	Vhat Country?
18 23e	erai	10211 Eyelet Court	2. Was Decedent Ever	in II S 12			Specific Ves es No	USA 14 Bass	e - American Indian,
ineri	Fun	11. Marital Status 12 Never Married 2 X Married 12	Armed Forces?	110.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Pue	to Rican, etc.)		k, White, etc.
el', or	þ	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify.	: Black
natur	Completed	15. Decedent's Educa (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	ation	orkina	16b. Kind of Bu	siness/Industry
e. Mer.	pp.	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	d)	anning .		
tygien f. f. f.		12 17. Father's Name (First, Middle, Last)	6	Audi	Ltor	10 34-45-4- 11-	- (First Middle 1		1 Govt.
and Menial Hygiene. Is marked other then eumetic event, the Me	Be	Unknown			!	Rosa	me <i>(First, Middle, N</i> Opher	naiden Sumami	θ)
mark metic	ို	19a. Informant's Name/Relationship (Type	e. Print)	19b. Maili	ing Address (Street			City or Town	State Zin Codel
27 is		Sharon Bellamy-Sim		Clinton,					
of Health of Item 27 i		20a. Method of Disposition	20	b. Place of Dispo					City or Town, State
nt: If		1 XBurial 2 □ Cremation 3 □ Rel 1 □ Donation 5 □ Other (Specify)		on Cemete		25/05	Arling	rton, VA	
Department of H Importent: If ite eny injury or otl once.		21. Sign ture of Funeral S		trickland , Camp Sp		1 Services MD 20748			
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the o	death. Do not en					
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Medical and strength and streng	edicai Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Hypertensi	ve Cardi				est,	Interval Between
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	1 - For State Registrar	State of Marylar		rtment of H		R	leg. No.	5 12812
Physiciar /Medica Examine	JOHN AL	BERT SAVOY,	JR.	4b. City, Town, or	Location of Dea	2. Date of Dea Month March 24	Day Y	Year 3. Time of Death 8:30A Death
Funeral Director	405 Kettering D			Upper Man		S. 8. Date of Birth	Prince	George's Birthplace (State or Foreign Country) Bish. D.C.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Evant and must be notified at once.	10e. Street and Number	George's Upp	ty, Town or Loc er Marl			1	og. Citizen of Wh	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
tural, or items	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? ed 1	1	☐ Yes 2 No	Specify:	Specify Yes or No- into Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. Black
be filed within 72 tal Hygiene. d other than "naleevent, the Medical Complete Comple	(Specify only highes Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, L	college (1-4or 5+)	(Give F	ent's Usual Occupa ind of work done of O NOT use retired C Driver	luring most of w	ame (First, Middle, i	~	ablic Works
of Health and Mental be of Health and Mental itam 27 is marked or other traumatic every	19a. Informant's Name/Relationsh Constance Savoy 20a. Method of Disposition	ip (Type, Print) /Wife	405 Ket	tering Dri	ve, Upper	Rural Route Number Marlboro, 1		
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Physician /Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Cholangioc Due to (or as a consequence)	arcinom		g, such as cardia	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
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sician: The law requirector, page 2 should					26 Place of Do	24a. Was a autops perform 1 Yes 2	y prio ned? dea 200 No 1	re autopsy findings available ir to completion of cause of th? Yes 2 \(\sumbole\) No
ng Phy Iter this Ineral d	examiner?	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	r: 4 Nursing	Home 5 🗷 Reside 28d. Describe ho	once 6 □Other ow injury occurred	(Specify) or Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the funaral Diractor.		Physician: To the best of my kno xaminer: On the basis of examina and manner stated.	owledge, death	occurred at the timestigation, in my op	e, date and plac	e, and due to the ca	ause(s) and mann	er as stated. If due to the cause(s)
To the within 3 To the comple	29b. Signature and title of certifier Rupa A	ho completed cause of death (Item	123a) (Tuna 5		number 1321	2:	9d. Date signed (1	Month, Day, Year)
State Registrar	Ruba A 31. Date filed (Month, Day, Year)	VARMA 32. Registrar's Signa	1221 Me		Lane, L	argo, MD	20774	

PRIVACION (Modical Examineto Examine			1 For Stete	State of Ma	aryland /	•			and Me	ntal Hyg	iene	005	12813
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Color Cases Females Cases Females Cases	C = 14 F			/ DAUGHTER				SE					
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27. Manner of Death XX Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28f. Location (Street and Number of Edity or Town, State) 28d. Describe how injury occurred 28d. Descri	an: T tificati	(0)	25. Was case referred to medical	TICS .				26 Place	of Death (C			1 ∐ Ye	s 2 No
29a. Certifier XXX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and due to the cause	ysici is cer direc			Hospital: Inpatie	nt 2 ER/C	utpatient 3 🗆 🗆	Oth	OF.				Other (Sp.	ecify)
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29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon	pital curs a ceral I		29a Certifier XIX Certifyin	n Physician: To the hest of	of my knowledg	le death occurre	d at the tim	ne date and	d place, and	I due to the ca	ause(s) a	nd manner a	e stated
2 7 July Lucy M.D. 158322 3/29/200	e Hos 24 h e Fur letely	dice	(Check only 2 Medical	Examiner: On the basis of	examination a	nd/or investigatio	n, in my o	pinion, death	h occurred a	at the time, da	ate and p	lace, and du	e to the cause(s)
2 (a)	To th within To th comp	Me	29b. Signature and title of certifier	0 00		29	9c. License	e number		29	9d. Date	signed (Mor	th, Day, Year)
() (O)	7		1 Straday	Zinost	M	. d	7 28	322	-		3/25	1/200	5
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIKHA KHOSLA, M.D. 3001 HOSPITAL DRIVE, CHEVERLY, M.D. 20785	(7)				eath (Item 23a)	(Type, Print)	DINE	CHE	AVER I	ALL Y	7 107	185	
31 Date filed (Month, Day, Year) 32 Registrar's Signature		ata	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	•	KIVU	, ,,,,	- V - I \ L	1 IND	207	75	
Registrar MAR 3 1 2005				5 Steel .	K A	and I							

Physiciar /Medica					incare	OI L	Death			Reg. No		10	128	
Examine	1 -	a. Facility Name (If not institution, give	orge Gordon (own, or	Location of De	N	. Date of De Month Iarch	27, Da	2005		3. Time o	
Funeral Director		Southern Maryland 6. Security Number 6. Sec 233-14-3891		enter vrs. last birthday) Yrs.	Clir If Under 1 Months		If Under 24 h	in. 8	Date of Bird (Month, Da			9. Birthp Cow West	rge place (State ptry) Virg:	or Fore
nyland how		Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	1	City, Town or Lo		on							0d. Inside 0	City Lin
r Items 23a or 28a-fs in at must be notified	2	10e. Street and Number 2211 Rosecroft Bly			10f. Zip C	20	0744				USA	Vhat Cour	ntry?	
tural; or Items	2	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1√CYes 2 □ No If Yes, Give Year or Dates:	TIT'T	Was Decede f Yes, specif 1 ☐ Yes 2		panic Origin? i, Mexican, Pu Specify:	(Specit lerto Ric	y Yes or No an, etc.)	-	Blac	e-Americ k, White, Whi		
of Hailt and Mental Hygiene item 27 is marked other than "nature other traumatic event, Ital Medical E. To Re Commission	on blere	15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Deced (Give life. L Cle)		Occupat done du retired)	tion uring most of a	working			ind of Bu	siness/In	dustry	
Mental Hy, arked othe attic event,	ם ב	7. Father's Name (First, Middle, Last) George H. Stevens					18. Mother's M Gertru	ıde	E. 5	Stro	ud			
permit. Tages I dure su Department of Health and Important: If item 27 is in any injury or other traum once.	I	19a. Informant's Name/Relationship (T) Elizabeth F. Steve 10a. Method of Disposition 1 🛣 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signatury Funeral Service Licens	nson/Wife Removal from State	2211 D. Place of Disposementery, crem Tlingtor 22	Rosec sition (Name natory or other Nat.	roft of er place Cen Address	ı	For	t Wash 5 Kalas	aing 20c. Lo	ton,	MD. 20 City or To	0744 wn, State	ia
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		4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe sician: To the best of my k	ocify)			date and =1		City or Town	n, State,)			ber,
within 24 hours to the Fune completely fill		(Check only one) 2 Medical Exami	ner: On the basis of exami and manner stated.	ination and/or invi	estigation, in	my opir	nion, death oc	curred a	at the time, d	ate and	place, ar	nd due to	ited. the cause(s)
9		0. Name and address of person who co		70		_	3446				27.			090

Physic		Decedent's Name (First, Middle, L								2. Date of De Month 03/30	Day	y Year	3. Time of Death 4:00 A
/Medi Exami		Saba S 4a. Facility Name (If not institution, qu	hahnawaz ive street and numb	er)		4b. City	, Town, or	Location o	of Death	03/30/	-	County of Dea	
Exami	iei	17 Capps Cour		•						y1and		ontgome	
Funeral			Sex 7.	Age (In yrs	. last birthday		er 1 Year	If Under Hours		8. Date of Bit	rth av. Year)	9. Bi	rthplace (State or Foreign
Director		108-68-0244	1 □ M 2 □ X F	42	41 Yrs.	Wighting	Days	110013	14141.	04/04/	63	Kab	ul,Afghanis
and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show may injury or other traumatic event, if a Medicul Eraird at must be inclifted at once.	ţō	Monteon	0 2 77	na.	ithers	huro							1 X Yes 2 □ N
r 28a	Director	Maryland Montgom 10e. Street and Number	егу	ga	TCHCIS		ip Code				10g. Citi	izen of What C	country?
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ems dear	by Funeral	11. Marital Status	12. Was Decede	ent Ever in t	J.S. 13.	Was Dece	edent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Whi	
or it	y F.	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	N o		1 ☐ Yes		Specify:				Specify	
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othe	Be C	17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	e (First, Middle			
uld by Menta Irked Itic e	ToE	Abdul Latif Ras	hid					A1	ia R	ashid			
and I		19a. Informant's Name/Relationship										r Town, State,	
and ealth m 27 her tr		Habib Simab/broth	er in law					boom					. 20874
ges 1 t of H if ite or otl		20a. Method of Disposition 1	☐Removal from Sta	ate	Place of Disponentery, cre	matory or	other place			Date	20c. Lo	ocation - City or	r Town, State
t. Pa tmen tent: njury		`4 Donation 5 Other (Spec	cify)	Мо	unt Co				3/31	/05	A1	exandr	ia,Va.
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Medical Examiner Asician and be burial-transit	dicai Examiner	shock, or heart failure. List onlinediate Cause (Final disease or condition	a. Due to (or b. Due to (or c.	n line. 1705 7	quence of):	nter the mod	de of dying	, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
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State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Elaine Sterner /Medical 2005 011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSPITAL Cumberland SACKED If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sep 24, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1□M 2√F Yrs. Director 218-68-4322 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic evant, the Mudical Examinar must be notified at MD Allegany Cumberland 1√ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11810 Aster Ave. Potomac Park 21502 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic avant. College (1-4or 5+) Elementary/Secondary (0-12) Office Administrator 12 Monumental Life 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Calvin M. Carder Lillian K. (Hare) Carder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11810 Aster Ave. Cumberland MD 21502 Dale Sterner husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Wesley Chapel Cemetery 4/13/2005 WV **Points** ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Lice 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SMALL CELL CARCINOMA CERUX **Physician** MITASTATIC 2002 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician The law requires that the death certificate be Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 Yes 2.2 No of Vital 2. Z No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 🗹 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide foth. within 24 hour. *he Funaral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11,2005. 002337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Zamas 625 Cumberland, ma Kent Ave 32 Registrar's Signature State Registrar APR 1 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:31 PM 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** towsan 509E. JOPPaRvao ML Manacare If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 ■ M 2 KF Hours Min 215-26 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show ? is marked other then "netural", or Items 23e or 28e-f shot treumatic event, it a Modical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e)a 110 filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Pennsylvania 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othing any lighty or other treumatic event 2008. Be Jesajah ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2851 Edgecombe Circle North, Baltimore, MD 21515 Hilda Byrd/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 Dother (Specify) Springhill Mem Gardens 3/28/2005 Salisbury, MD 21. Signature Funeral Jervis Lisenge 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 nterphe mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not ente Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
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1 Tes 2 The Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b Time of 28d. Describe how injury occurred 5 Pending 2 Accident Ivatural 1 ☐ Yes 2 ☐ No investigation death. s after death If Director: A d in by the fo 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funerel [1 Certifying hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the cause 29a. Certifier (Check only one) 2 Medical € investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) icense number 30. Name and address of person who com leted ca of death Ayman Akkad

DHMH 17 Rev 1/2001

State

Registrar

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APR 0.1 2005

31 Date filed (Mont

32. Raistrar's Signature

wsen, MD 21204

THOMPSON

CATHERINE

	•		For Stata Registrar	State	of Marylar		artment of H			giene Reg. No.	711115	128	19
		1	Decedent's Name (First, Midd	lle, Last)					2. Date of De			3. Time of Dea	ith
	Physicia /Medic		Amelia	L	T	ysinger	•		APRIL 0	7 2	.005	1410	М
	Examin		4a. Facility Name (If not institution		u <i>mber)</i>			Location of Death	h		County of Deat	h	
g -		Ž*	MEMORIAL HOS 5. Social Security Number	PITAL 6. Sex	7. Age (In yrs.	last hirthday)	CUMBERI If Under 1 Year	LAND If Under 24 Hrs.	8 Date of Bir		LEGANY	hplace (State or Fo	roige
	. Funeral Director		217-10-1253 Usual Residence of Decedent	1 M 2 K	88	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Jun 24	1, 19	16	VA	reign
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo						10d. Inside City Li	mits
	h the Maryland r 28a-f show	tor	WV Mir	neral		Wiley	y Ford					1□Yes 2√]No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	untry?	
	ours after death with rel', or Items 23s or Examiner must be	la	P.O. Box 47	40.111.5		10		26767	// W N		USA	don testing	
	ter de Items	-une	11. Marital Status 1 □ Never Married 2 □ Ma	Armed F	cedent Ever in U Forces? : 2 T.No	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	o Rican, etc.)	-	 Race - Ame Black, White 		
20	urs af	þ	3 □ Widowed 4 🛣 Divorce	d If Yes, G Year or	2 No Sive X Dates:		1 ☐ Yes 2 🗷 No	Specify:			Specify: wh	ite	
9500-61212	72 hours "naturel", Jical Ex.	Completed	15. Decede	nt's Education	1)	16a. Dece	dent's Usual Occupa	ation during most of wor	rkina	16b. Ki	nd of Business/		
7	l within 72 iene. r than "n	du du	Elementary/Secondary (0-12)	1	(1-4or 5+)		kind of work done of DO NOT use retired	0	3	-			
	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Items 23s or 28s-f show ent, it o Modical Exemitive must be notified at		12 17. Father's Name (First, Middle	. Last)		labore	:r	18. Mother's Nan	me (First, Middle,	Tex:			
Maryland	ed all be	To Be	Charles H. F	lardy Tysir	nger				lice Sco			er	
	s t and 2 should Health and Mer Item 27 Is marke other treumetic		19a. Informant's Name/Relation Arnold Zirk		riend		ng Address (Street a	a <i>nd Number</i> or Ru	ral Route Number			(ip Code) IV 26753	
<u>a</u>	of Hee		20a. Method of Disposition	2		Place of Dispo	esition (Name of matory or other place	e)	Date	20c. Lo	cation - City or	Town, State	
Ĕ	Pages ment of ent: If it		1 ☐ Burial 2 ☐ Aremation 4 ☐ Donation 5 ☐ Other (Scale	arpelli Fu	ineral Home	, PA	4/8/2005	Cre	esaptow	n MD	
Baltimore,	permit. Pag Department Importent: eny injury once.		21. Signature of Funeral Service	Licensee	1111	- 22	•	li Funeral H				_	
			23a. Part1. Enter the disease, of	or complications that	caused the deal	th. Do not ent	er the mode of dying	jinia Avenu g, such as cardiad	e: Cumbe or respiratory a	rland, rrest,	MD 2150	Approximate	
	Physician		Immediate Cause (Final	t only one cause on		ACEDED	DAT HEMOT	DIIACE				Onset and Death	
	/Medical		disease or condition resulting in death)		o (or as a consec		RAL HEMOF	KRIAGE				HOURS	
	Examiner		Sequentially list conditions.	b									
1/	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	quence of):							
¥	xecuti and	Examiner	that initiated events resulting in death) Last	c	o (or as a consec	quence of):							
/60,	ate be executed hysician and the burial-transit	calE											
9	tificating phy			-									
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregn birth 2 ☐ Feta gnant at time of a mown	al death 3□	Ectopic pregnancy Other (specify)			2	23d. Date of del	very Day Year	
2	res that t igned by be detac		Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of death	?
rds	quires n sigr ald be	ed by	CRITICAL AORTI	C STENOSI	S				1 🗆 '	Yes 2[□No 3□Pr	obably 4 Unkn	own
ecords,	The taw requires that the te has been signed by the bage 2 should be detache	Completed	MALNUTRITION,	CONGESTIV	E HEART	FATLUR	E		24a. Was		24b. Were au	topsy findings avail completion of cause	able
r	The tav	mo:							autor perfo	rmed? 2X No	death?		OI
Vital	ician: The certificate rector, pag	Be	25. Was case referred to medic examiner?						ath (Check only o				
to	Physic this or	은	1 ☐ Yes 2) No		` '	ER/Outpatier		4 Nursing n	lome 5 Resid			cify)	
	ng f fter mer	lon	27. Manner of Death 1 Natural 5 ☐ Pend	ing (Mo	e of Injury onth, Day Year)	28b. Time of Injury	Work	yat k? Yes 2 □ No	28d. Describe I	now injur	y occurred		
Division	Attendi death ctor: A	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	ce of Injury - At h	ome, farm, str	reet, factory, office					ral Route Number,	
2	el or / s after of in b	Certification:	4 Homicide determ	buil	ding, etc. (Speci	fy)			City or To	wn, State,)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (ing Physician: To the Examiner: On the and ma									
	To the within To the complete	Me	29b. Signature and title of certifi	er /		[. \	29c. License				e signed (Monti		
}			Laner	Call	2	Mr)		54411		APRI	.ь 2	.005	
	5		DR. BEVERLY CAL	n who completed ca KINS 500			Print) NUE SUITE	105 CUI	MBERLAND	, MAR	YLAND	21502	
	Sta Registr	•	31. Date filed (Month, Pay, Yea,	4 2005	egistrar's Sign	ature							
DH	MH 17 Rev 1/2				WIND CO.	AST AS							

			1 - State Registrar	State of Marylar		artment of Hertificate of L			liene 005	12820
	D		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th	3. Time of Death
	Physici /Medic		Minnie Gosha Wri	ght				March	29 2005	0054 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4c. County of De	ath Comico			
	Funeral Director		5. Social Security Number 6. Se 419–48–2796	7. Age (In yrs. 66	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year) (irthplace (State or Foreign Country) Alabama
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Mary	tor	MD Wicomico	Sa	alisbur	ТУ				1 Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			Og. Citizen of What C	Country?
	ath with the Marylan 123a or 28e-f show nat be rediffed al		1103 Parsons Rd.	, Apt. B		21801			U.S.	
36	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "naturel", or Items 23a or 28e-f show event, I'm Medical Exertil with a state in tilling a	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	1	Was Decedent of His fYes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
21215-0036	2 hour	edt	15. Decedent's Edu		16a. Deced	dent's Usual Occupa	tion		16b. Kind of Busines	
215	within 72 ene. then "na	plet	(Specify only highest grad	completed) College (1-4or 5+)	(Give	kind of work done di DO NOT use retired)	uring most of work	ring	Top. Time of Deamos	amoustry
7	filed with Hygiene. Ither ther	Completed	11	College (1-401 54)		Linewor	ker		Food Man	ufacturing
nd	ild be filed lental Hygi ked other ic event, L	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	
ya	should be nd Menta s marked umatic ev	T _o	Nathan Gibson	District.	401 44 11		Jennie			
Maryland	nd 2 sh lith and 27 is n r treun		19a. Informant's Name/Relationship (T) Jerry Gosha/son	pe, Print)					, City or Town, State,	
	l ar fea m		20a. Method of Disposition		Place of Dispo	sition (Name of			sbury, MD 20c. Location - City o	
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ I	temoval from State	•	natory or other place	. !		estimate of the	
Ħ	mit. F partme porter injur		21. Signature Liquid Service Licens	- OLG	22	es Mem Pa	s of Facility		Salisbury	, MO
ä	Depar Impo		(11)			ewis N. W				
بالنهز	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line. ASCV		er the mode of dying	, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
	LAUITINICI	er	Sequentially list conditions,	Due to (or as a conseq	uanaa oft.					
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	derice or.					
Ć,	ficate be executed physician and is the burial-transit	Examin	resulting in death) Last	Due to (or as a conseq	uence of):					
68760,	ysicia ysicia	dical		d						
	rtificat ng phy as th		IS SENALS							
P.O. Box	that the death certific led by the attending pl detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
	S Pro	by Pl	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cause giver	n in Part I.	23e. Did tot	pacco use contribute (to the cause of death?
ord	w require been sign	ted	severe PVB				-	1 🗆 Ye	es 2□No 3⊡P	robably 4 Unknown
I Records,	The law ate has b page 2 sl	Completed						24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of s
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Jamital:			26. Place of Deatl	h (Check only on	θ)	
of		- To	1 Yes 2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ER/Outpatien 28b. Time of		4 Nursing no		nce 6 Other (Spe	ecify)
on	fe fe	Certification;	1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury : Work? M 1 7	at ? es 2 □ No	280. Describe no	w injury occurred	
Division	Attending r death. ector: Afte	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, stre				reet and Number or R	Tural Route Number,
Ö	al or safter	Serti	4 Homicide determined	building, etc. (Specif	y)			City or Towr	, State)	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	one)	ician: To the best of my known on the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my opi	e, date and place, nion, death occurr	and due to the cared at the time, do	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of centier			29c. License			9d. Date signed (Mon	th, Day, Year)
•	3			U		H5	0471	- 2	124/2005	
	Sp			DO E CARROLL	51.	Sal13b	0497 ury, n	26 '		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 2	32. Polistrar's Signa	ture	medi				

FREDERICK	W.	WARNICK	SR.

SDE	RICK W.	W	ARNICK SR. 1 - State Registrar		State of	of Maryla	and / Depa <i>Cei</i>			ealth a Death	and M	•	gien Reg. Na	20	ng	100		
	Physic								ck, Sr. 2. Date of Do				eath 3. Tirl		3. Time of Death	/ /		
	/Medi Examii		4a Facility Name (If o	ot institution, give	street and nu	mber)		^{4b.} City	VČOC	Location o	of Death			WASHI			_	
	Funeral Director		5. Social Security Num 215-56-869 Usual Residence of D	91 1	9x ∑ M 2□F	7. Age (In yi 54	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt Month, 19 July 19	th y, Year	950 Ma	Birthpla Coupt Ty I	ace (State or Foreig ny) and	n	
	h the Maryland ir 28a-f show	irector	10a. State 1	ob.county Hampshir	e		City, Town or Lo	cation	Code				10g. Ci	tizen of Wha		od. Inside City Limits 1 X Yes 2 □ No		
0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exam art mat be notified at once.	d by Funeral Director	230 E. 11. Marital Status 1 □ Never Married 3 □ Widowed 4			ve XNo					gin? (Spec , Puerto P	eity Yes or No- lican, etc.)	US.	14. Race -	White, e	tc.		
21215-0036	filed within 72 h Hygiene. other then "nati ent, the Wedica	Completed	(Specify Elementary/Second		ucation de completed) College (1-4or 5+)		kind of wor OO NOT us	rk doné d se retired) Dire	ector				ind of Busin				
Maryland	hould be fii d Mental H nerked ott natic even	To Be	17. Father's Name (Fi	н.	Fred	i		nick		Jean	n Ela	(First, Middle, Line Bo	a1					
	ges 1 and 2 s t of Health an If item 27 fs i or other treus		19a. Informant's Nam Debra Ani 20a. Method of Dispos 1 Debra 2 0	n Warnic	k	Cana	230 Place of Disposementary, crem	E. Ma	ain S	St., 1	Romne Da		26°	757 ocation - City	y or Tow	n, State		
Baltimore,	permit. Pa Departmen Important: any injury once.		° 4 □ Donation 5 21. Signature of Fune	Other (Specify	see ,	MO1033		Name an	d Addres	s of Facility	Shaf	2,2005 fer-Wa ney, W	rni	_				
68760,	Physician and // Medical Examiner but special and pure representations of the provided in the	cai Examiner	edicai Examiner	23a. Part1. Enter the shock, or heart f Immediate Cause (Fir disease or condition resulting in death) Sequentially list condition and the sequentially list conditions. Enter Underly Cause (Disease or initing that initiated events resulting in death) Las	tions, adiate ing	Due to	ach line.	guence of):					respiratory ari	rest,			Approximate nterval Between Onset and Death	
P.O. Box 68	the death certif by the attending ached for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pring the past 12 mc 1 Yes 2 N 9 Unknown	onths?		irth 2 Fe ant at time of	tal death 3 🗌	Ectopic pre Other (spe						23d. Date of Month		r Day Year		
	w requires that been signed t should be det	by	Part II. Other significa	nt conditions co	ntributing to de	eath but not re	esulting in the un	derlying ca	ause giver	n in Part I.		23e. Did to		,		cause of death?		
of Vital Records,		e Completed	25. Was case referred	to modical							_		sy med? 2 □ No	prior	to comp	y findings available pletion of cause of No	F	
Division of Vir	ul or Attending Physician: after death. Director: After this certific of in by the funeral director,	Certification; To B	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 2 Accident		28a. Date of Month	of Injury h, Day Year) 29, 2005	home, farm, stre	Р М	A Other 8c. Injury Work?	4 □ Nur	sing Home 28 o	d. Describe ho	ence ow injur treet an	Shot d Number of	s e	AT SCENE		
	To the Hospital or Al within 24 hours after o To the Funeral Direc completely filled in by	edical	29a. Certifier 1 [(Check only 2X	Certifying Phy Medicel Exami	sicien: To the ner: On the ba and mann	asis of examin	nowledge, death	occurred a estigation,	at the time in my opi	o, date and nion, death	nlace an	d due to the c	ause/s)	and manner	r ac ctat	ed. ne cause(s)	_	
)	To the I	W	29b. Signature and title	of certifier	Mee	nhe	MO	29c.	License OCM			2		e signed (Me RCH 30				
ÓH			30. Name and address TOShO	Z Give	enbe	My N	23a) (Type, P		1 Per	nn St	reet	Balti	mor	e, Mar	ylaı	nd 21201		
	Sta Registr		31. Date filed (Month, A	PR 0 1 20	105 32. 8	egistra)'s Sigr	d.	while of										

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	1	1-3	1	- 2
- 1	fire	U	Eine	6

		1 - For State Registrar		Ce	rtificate of l	Death	R	eg. No.			
Ohyci	oian	Decedent's Name (First, Middle, Las	1 .				2. Date of Dea Month	th Day	Year	3. Time of Death	
Physic /Med		Robert Eugene W	Theeler, Jr.				MARCH	29 20		6:05 a	
Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County	of Death		
		St. Mary's Hospi	tal		Leonar	dtown,		St.	Mary	's	
Funera	1	5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1	9. Birth	place (State or Foreigntry)	
Directo	r	None /	M 2□F One	Hour Yrs.	L. Days	1	March 29			yland	
pu ,		Usual Residence of Decedent									
anyla shov	_	10a. State 10b. County		oc. City, Town or Lo	ocation					10d. Inside City Limit	
Ba-f.	Director	Maryland St. Ma	ry's	Lexingt	on Park					1 ☐ Yes 2 X]N	
ith th	- Si	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Cou	ntry?	
th w 23e	20	21645 Saratoga	Drive		20653			U.S.A			
4 within 72 hours after death with the Maryland jiene. Jiene. r than "neturel", or items 23e or 28a-f show	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Rao		can Indian,	
or it	E.	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1 □ Yes 2 X No		1110431, 010.7			etc.	
of 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other than "neturel", or treumetic event, I. w. Madic. Exami	dby	3 Widowed 4 Divorced	Year or Dates:		1 1 1 es 2 (A 100	Specity.		Specify	Whi	te	
72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Bu	siness/Ir	ndustry	
thing it	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	9				
	Ö	0		Not	ne			None			
be filed tal Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i	Maiden Sumam	Θ)		
should be a ind Mental I marked o	2	Robert Eugene Wh	eeler			Laurie	Beth Tr	ujillo			
2 sho and 1 is me		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailie	ng Address (Street a	and Number or Rur	al Route Number	, City or Town,	State, Zij	Code)	
		Robert E. Wheeler	/ Father	P.O.	Box 1411	Lexingt	on Park	Marv1	and	20653	
t He item		20a. Method of Disposition		Ob. Place of Dispo				20c. Location -			
Pages nent of int: If it		1 ☐ Burial 2 X Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify,	Removal from State	•	ld-Echol:		31-05	Thom lot	en II.	-11 MD	
	à	21 Signature of Funeral Service Licens	_		2. Name and Addres			Charlot		ome, P.A.	
permit. Departrimports any injector	A	Shul NIS	()		.O. Box 2		rdtown	Marvla	al 20	0650 0270	
		23a. Part1. Enter the disease, or comp	lications that caused the						.1u 2	Approximate	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. EXTEME PREMATURITY (22 Weeks gestation)									
Physician /Medica	_	disease or condition resulting in death)	a extreme	premar	turity (22 Week	s gestat	70n)			
Examine			Due to (or as a co	on — uence of):	1		9				
	e e	Sequentially list conditions,	b. Due to (or as a co	at any market and and					-		
ed is	ji.	Sequentially list conditions, if any, iscome to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	500 to (51 de 21).	inequalica or;							
eecut and I-trar	Examin	that initiated events resulting in death) Last	c	vasediliance of):							
cian cian			000 10 (01 23 2 00	missiquomos ory.							
tificate be executed gphysician and as the burial-transit	edical		d								
entific ling p		IF FEMALE:									
death cer e attendir	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Date Mor		ery Day Year	
e deg	Sic	1 Yes 2 No	4☐Pregnant at time 9☐Unknown	e of death 5	Other (specify)			IVIO	1611	Day rear	
that the death cert ed by the attendin detached for use	Physiclan/N										
The law requires that the has been signed by age 2 should be deta	by I	Part II. Other significant conditions co	intributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob			he cause of death?	
w requir been s							1 □ Ye	s 2 O No	3 🔲 Prob	pably 4 Unknown	
he law requires t e has been signe age 2 should be o	Completed						24a. Was a		Vere auto	psy findings available	
The lay ate has page 2	E						autops	ned? d	eath?	mpletion of cause of	
	O	25. Was case referred to medical				26. Place of Deatl			Yes	2 No	
Physicien: this certific	0	eyaminar?	Hospital:	2 ER/Outpatien	t 3 DOA Othe	V.					
	I	27. Manner of Death	28a. Date of Injury	28b. Time of			me 5□Reside 28d. Describe ho			у)	
ding Phy h. After thi funeral c	후	1 Natural 5 Pending investigation	(Month, Day Ye	ar) Injury	Work	:? /es 2 □ No		, , , , , , , , ,			
or: or	ca	3 ☐ Suicide 6 ☐ Could not be	28e Place of Injury	At home farm str			28f Location /St	/Street and Number or Burel Doute Number			
or A after Direction by	T.	27. Manner of Death X Natural							or or mura	i noute reamber,	
To the Hospitel or Attraction within 24 hours after de To the Funerel Direct completely filled in by the		29a. Certifier 1 Certifying Phy	rejejen. T- the 5 3 4 4	a demonstration of the second		a data and i					
Hos 14 ho Fun Fun	edical	(Check only 2 Medicel Exem	sician: To the best of miner: On the basis of exa	y knowledge, death Imination and/or in	restigation, in my op	ie, date and place, pinion, death occurr	and due to the ca ed at the time, da	tuse(s) and mai ate and place, a	nner as s nd due to	tated. the cause(s)	
the the	Med	one)	and manner stated.		29c. License	number		9d Data sience	/Adamsh	Day Vasal	
		29b. Signature and title of certifier	/					9d. Date signed		Day, rear)	
5 × × 5		TIX XOUIT	2UM.MD		10006	2332	3	131/05			
M.ii		7777	/		- 0	-002					
T with		30. Name and address of person who c	7		Print)			//			
T with		30. Name and address of person who c ERIN HICKEY ST. 31. Date filed (Month, Days)	MARY S HOS		Print)		50				

RUBERT EUGENE WHEELER JR

				-		of Health of Death			Reg. No.	12823
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ethel Peet Wilson					2. Date of De Month March	Day Yea	3. Time of Death 8:50 P M
	Examin		4a. Facility Name (If not institution, give street and number)		•	wn, or Location			4c. County of De	eath
			Villa Rosa Nursing Home	2.45 4		hellvil				George's
	Funeral Director		5. Social Security Number 216-44-9317 Usual Residence of Decedent 6. Sex 1 M 2 M F 7. Age (In yrs. last bin 97)	Yrs.	If Under 1 \	Year If Under Days Hours	Min.	8. Date of Bir (Month, Da April	th ly, Year) 23, 1907 Ma	Birthplace (State or Foreign Country) Aryland
	yland yland		10a. State 10b. County 10c. City, Town	vn or Loc	cation		-			10d. Inside City Limits
	e Mar	ctor	Maryland Prince George's Chever	rly						1 ∑Yes 2 ☐ No
	with the	Dire	10e. Street and Number		10f. Zip Co				10g. Citizen of What	Country?
	eath v	erai	2702 Belleview Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	13 W	20785		igin? (Sp.	poity Van or No	U.S.A.	nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic event, I've Medical Exactiner must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give	1	Yes, specify	t of Hispanic Or Cuban, Mexica No Specify		Rican, etc.)	Specify:	
Maryland 21215-0036	2 hou	ted !	15. Decedent's Education 16a.	. Deced	ent's Usual C	Occupation			16b. Kind of Busines	
215	thin 7.	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k life. D	kind of work of OONOT use r	done during mos retired)	st of work	ing		·
2	led wi lygien har th	Con		udge	et Anal	_			U.S. Gove	rnment
and	d be fill ntal H ad otl	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
2	should nd Me mark matic	٦	Fred Peet 19a. Informant's Name/Relationship (Type, Print) 19b.	b Mailing	n Address /S			len Sti	reaks er, City or Town, State	Zin Code)
<u>8</u>	nd 2 s lith ar 27 ts r trau								ly, Maryla	
altimore,	of Heal		20a. Method of Disposition 20b. Place of	of Dispos		of		Date	20c. Location - City	
Ē	Page nent c ant: If ary or		1 Ma Buriai 2 □ Cremation 3 □ Hemoval from State	•	•		3/30	/2005	Upper Mari	lboro, MD
Balt	permit. Departrimporte any inju		21. Signature of Puneral Service Licensee						ineral Home	e, P.A.
)	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the condition of the co	not ente	or the mode o	f dying, such as	cardiac o	or respiratory a		Approximate Interval Between Onset and Death
8760,		ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen							
O. Box 687	ath certifii ttending p or use as	Physician/Medical	d		Ectopic pregr Other <i>(speci</i> i				23d. Date of d Month	elivery Day Year
rds, P.	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in	-			se,		obacco use contribute	to the cause of death? Probably 4 □Unknown
Reco	rsician: The law requir s certificate has been sli lirector, page 2 should b	Completed	Osteoarthrilis Breast Hypothyroidism	L C	ance				prior to	
ita	lan: rtifica	a	25. Was case referred to medical			26. Place	of Death	1 ☐ Yes	2 No 1 Ye	es 2 No
Division of Vital Records,	ing Phy liter this	ion: To B	1 Natural 5 Pending (Month, Day Year) Ir	utpatient Time of Injury	28c.	Injury at Work?			dence 6 Other (Sp	ecify)
Division	al or Attandi s after death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)		M 1 ☐ Yes 2 ☐ No et, factory, office 28f. Location (Streen City or Town,			Street and Number or I vn, State)	Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	e, death	occurred at to estigation, in	he time, date ar my opinion, dea	nd place, a	and due to the ed at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title orcentitier			cense number			29d. Date signed (Mor	nth, Day, Year)
Λ			MA			310	01		March 25,	2005
K	-(2)		30. Name and address of person who completed cause of death (Item 23a) (
		• 0	Stuart J. Turkewitz, M.D. 7500 Gr 31. Date filed (Month, Day, Year) 32. Registrar's Signature		way Ce	nter Dr	ive	#430 , G	reenbelt,	MD 20770
	Sta Registr	-	MAR 3 1 2005	had	U					

			1 - For Registrar	State of Ma	ryland / Depa	artment of F			/11115	12821
			Registrar 1. Decedent's Name (First, Middle, Last)	Oei	uncate or i	Dealli	2. Date of Deat	b.	3. Time of Death
п	Physicia	an			Wahatar	T 20		Month March	27 2005 Year	8:40 a M
	/Medic		George Will 4a. Facility Name (If not institution, give	lliam	Webster,		r Location of Death	March	4c. County of Death	0.40 a
	Examin	er	Calvert Memorial				Frederick		Calvert	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.			ace (State or Foreign
	Director		579-50-6476	0 M 2 □ F 6	4 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 5,	1940 Wash.	, D.C.
	D .		Usual Residence of Decedent							
	arylar show	_	10a. State 10b. County MD Calvert		10c. City, Town or Lo	cation Huntingto	OTATO		10	Od. Inside City Limits
	Ba-f	Funeral Director				10f. Zip Code				1 ☐ Yes 2 No
	vith th	Dire	10e. Street and Number 1310 Wilson Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was If Y					0g. Citizen of What Coun	try?	
	ath v	rai					39	USA		
	er de	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married		ever in U.S.	Yas Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	Rican, etc.)	14. Race - America Black, White, e	
36	irs af	by F	3 ☐ Widowed 4 🏋 Divorced		I□Yes 2XINo	Specify:		Specify: wh	ite	
21215-0036	72 hours after death with the Maryland natural; or Itama 23a or 28a-f show Jisal Exan at munt be notified at	ted	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occup	ation		16b. Kind of Business/Ind	lustry
215	hin 7	ple	(Specify only highest grad	College (1-4or 5	+) (Give	Kind of work done of OO NOT use retired	during most of work d)	ing		
2	ad wit	Completed	11		plumb	er			constructio	n
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	- 1	G		18. Mother's Name			
Maryland	should nd Men marka imatic	은	George William W		Sr.	a Address (Street		ary al Route Number.	Salsinger City or Town, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Importent; If item 27 is marked other than "natural; or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Exertment than the profile of any once.		William Anthony We		., son 1	310 Wilso	on Rd., H	untingto	wn, MD 206	39
Baltimore,	ges 1 t of H if ital		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F	Removal from State		natory or other plac	(e)		20c. Location - City or To	wn, State
Ë	t. Pa tmen tant: njury		' 4 □Donation 5 □Other (Specify)		Metropoli			0-05 <i>I</i>	Alexandria,	VA
Bal	Departiment of the popular in pop		21. Signature of Funeral Service Licens			. Name and Addre				
			23a. Part1. Enter the disease, or comp	lications that caused			neral Hom			D 20736 Approximate
Н			shock, or heart failure. List only o	ne cause on each lin	e.	or the mode or dyin	ng, such as cardiac t	or respiratory arre	531,	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. 31/4	red Car	dwmy	opally	,		
П	Examiner			Due to (or as a	consequence op:	0	/ /			
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (gr as a consequence of): Due to (gr as a consequence of):							
	cuted id ransit	mir								
o,	ate be executed hysician and he burial-transit	Ex	resulting in death) Łast	Due to (or as a	consequence of):					
8760,	cate be executed physician and the burial-transit	lical	(d						
9 ×	entifica ling ph	Mec	IF FEMALE:	22- 14						
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of deliver Month	ry Day Year
	es that the death certific igned by the attending p be detached for use as	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at 9□ Unknown	time or death 5	Other (specify)				
P.0	that the by detail	'Ph	Part II. Other significant conditions co	ntributing to death by	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to the	e cause of death?
Vital Records,	uires I sign Id be	d by	Respuelo	1 taile	re			1 □ Ye	s 2 No 3 Proba	ably 4 Unknown
CO	w require been si should b	lete	Cargestar	hoart	L. O	4		24a. Was ar	24b. Were autor	esy findings available
Re	he lav e has age 2	Completed	- Corgonal	/ Con	Jacoba	<u> </u>		autopsy	prior to con death?	npletion of cause of
ta	ician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Death	1 Yes 2		2 □ No
	Phyaician: The I this certificate ha al director, page	To B	examiner? 1 ☐ Yes 2 Z No	Hospital: 1 ☑Inpatier	nt 2 ER/Outpatien	t 3 DOA Oth	or		nce 6 Other (Specify)
n of	ng Ph fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injun World	y at k?	28d. Describe ho	w injury occurred	
Sio	andii eath. or: A he fu	catle	2 Accident investigation				Yes 2 □ No			
Division	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use as to completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Str City or Town	eet and Number or Rural , State)	Route Number,
	spita nours neral		29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowledge, death	occurred at the tin	ne, date and place,	and due to the ca	use(s) and manner as sta	ited.
	he Ho in 24 ha Fu pletel	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination and/or invited.	estigation, in my o	pinion, death occurr	ed at the time, da	ite and place, and due to	the cause(s)
	with To t	Σ	29b. Signature and title of certifier			29c. License	e number	7 29	d. Date signed (Month, E	Day, Year)
			- Forgo	NW)		10:	5/30	3	3/28/0	7
	1		30. Name and address of person who co	empleted cause of de	0 2 - 1	on Sque	are Ar	lucato.	Modran	~ < >
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra		11 - 10		noisy	1-10 206	
	Registr		APR 0 1 2005	9 H	Societé D					

			State of Maryland / Departm	nent of Health and Mocate of Death	lental Hyg	6000	12825
			Registrar 1. Decedent's Name (First, Middle, Last)	Date of Boutif	2. Date of Deat	eg. No.	3. Time of Death
	Physici /Medic		Samuel Abeitha Walton		March 26	5, ^{Day} 2005 Year	17:50 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Death		4c. County of Death	1
				rince Frederick		Calvert	
	Funeral Director		578–36–9108 15¼M 2□F 75 Yrs. Mor	Inder 1 Year If Under 24 Hrs. Oths Days Hours Min.	8. Date of Birth (Month, Day, Apr. 24.	9. Birth Co. 1929 Cali	place (State or Foreign Intry) fornia
	pur		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits
	Maryik Febro	ō		•			1 ☐ Yes 2 ☒ No
	the h	Director	MD Calvert Solomons	f, Zip Code	10	0g. Citizen of What Cou	intry?
	with Se or			20688		U.S.A.	
	leath ms 23	era	11740 Asbury Cir. Apt. 1314 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	ican Indian,
(O	riter or	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No		Rican, etc.)	Black, White	, etc.
<u>ල</u>	rei', c	þ	3 ☐ Widowed 4 ☐ Divorced	es 2. No Specify:		Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland sne. then "neturel", or items 23e or 28e-f ehow he Medical Examinar must be notified at	Completed	(Specify only highest grade completed) (Give kind of	Usual Occupation of work done during most of work	ina	16b. Kind of Business/li	ndustry
2	uthin ne. hen	ш	Elementary/Secondary (0-12) College (1-4or 5+)	OT use retired)		Washington	I ight /Coc Co
7	filed v Hygie other ti	ပိ	17. Father's Name (First, Middle, Last)	VISOI 18. Mother's Name			Light/Gas Co
Maryland	o d in b) Be		Elsie		Kapalka	
<u></u>	shoutd nd Men marke imatic	ှင		dress (Street and Number or Rura			p Code)
<u>S</u>	and 2 sealth ar n 27 is			Bayfront Rd. I			,
Baltimore,	f Heal		20a. Method of Disposition 20b. Place of Disposition	(Name of [Date 2	20c. Location - City or T	own, State
Ë	Pages nent of ant: if its ury or o		1 M Buriai 2 U Cremation 3 U Hemovai from State	erans Cem. 3-31	L-2005 (Cheltenham.	MD
a	mit. partir porte y inju			ne and Address of FacilityLee			
m	P S E E G		Danielle Mard Lud 8125	Southern Mary	land Blv	d. Owings,	MD 20736
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac of	or respiratory arre	est,	Approximate Interval Between
B	Physician		Immediate Cause (Final disease or condition	OPD			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	_			
	Lxammer		Sequentially list conditions, any leading to immediate b. Due to (or as a consequence of):				
	ed sit	nine	Cause Disease or injury			_	
•	xecul and al-trar	Examiner	that initiated events c				
760,	ate be executed hysician and the burial-transit	calE	d				
89	tificati ig phy as the						
ŏ	death certifical e attending phy of for use as th	N/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ector	pic pregnancy		23d. Date of deliv	
.O. Box	0 0 2	sicie	1 Yes 2 No 4 Pregnant at time of death 5 Othe	or (specify)		Month	Day Year
<u>Т</u>	that the de led by the a detached f	by Physician/Med	9 Unknown		OG - Did tob	acco use contribute to t	ha anna at d162
က်	98 Pg		Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	1 239. 1010		pably 4 □Unknown
Š	w requir been si should	etec					
Rec	has ge 2 s	Completed		-	24a. Was an autopsy perform	y prior to co	opsy findings available impletion of cause of
Division of Vital Records,	ysicien: The is certificate he director, page	ပ္ပ	25. Was case referred to medical	OR Plant of Death			2 No
\equiv	Physicien: r this certifice ral director, p	To Be	examiner?	26. Place of Death		nce 6 □Other (Specia	64)
ō	g Phys er this eral di		27. Manner of eath 28a. ate of Injury 28b. Time of		28d. Describe ho		97
0	Attending ir death. ector: After by the funer	atio	Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M				
<u> </u>	of or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Str. City or Town,	reet and Number or Run , State)	al Route Number,
	itel or A			<u> </u>			
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in It.	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occur (Check only one) And manner stated	rred at the time, date and place, a ation, in my opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as s ite and place, and due t	tated. o the cause(s)
	To the within 2 To the complet	Mec	and marrier stated.	29c. License number	29	d. Date signed (Month,	Day, Year)
	FRES		Mana	Drorns	1	7.0.1 25	200
	. 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	U305/A		numer of 1,	2008
	10		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, no 110 Hospital 31. Date (ijed (Month, Day, Year) MAR 2 9 2005	Rd suite 210 H	Prince Fre	derick MI	20678
	Sta	_	31. Date (illed (Month, Day, Year) 32. Registre's Signature	lanks			
	Registr	ar	MAK & J LUUD PROBLEM S. A.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAMEND ITEM #11PER INF.G843 5 Perfice at the Inf.G84 Reg. No." 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month John W 0136 AM March 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Hospital (2055 1-60/4 Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□F Months Days Hours 185-26-1239 70 1934 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1 X Yes 2 ☐ No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1901 Elton Road 20781 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed → ₩ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Zonts Catherine Hempsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 19a. Informant's Name/Relationship (Type, Print) Michelle Zonts - Daughter 4714 Cherokee Street, Apt. Tl, College Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4/1/2005 Alexandria, Virginia 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Furjeral Service/Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Part¹. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severe Emphysema Immediate Cause (Final disease or condition

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rai', or itams 23e or 28a-f shov Examinar mast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 2 any injury or other freumatic event, If a Medical Ever it with the response.

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

the Maryland

the Hospitei or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

efter death. | Director: Af

24 hours e a Funerai I within 2

	resulting in death)	Due to (or as a consequence of):	· · · · · ·
cal Evalunci	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
iysiciaii/ivied	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
ed by r.	Part II. Other significant conditions of	1.5	Did tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 □Unknown
combier		24a.	Was an autopsy performed? Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 22 No
9	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
2	1 Yes 2 No	Hospital: 1 Inpatient Impatient Impa	Residence 6 Other (Specify)
ation:	27. Manner of Death Natural 5 Pending Accident investigation	(Month, Day Year) Injury Work? M 1 Yes 2 No	cribe how injury occurred
2010	3 Suicide 6 Could not be 4 Homicide determined	286. Flace of mury - At nome, farm, street, factory, office 201, Local	tion (Street and Number or Rural Route Number, or Town, State)
מוכמו	29a. Certifier (Check only one) Certifying Physical Exemption	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to niner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
Ä	29b. Signature and title of certifie	29c. License number	29d. Date signed (Month, Day, Year)
		M.D. 055846	3/30/05
	30. Name and address of person who of Jajo - Goule	completed cause of death (Item 23a) (Type, Print) who, MD. 11161 Now Hampshire Ave #2	201 Silver Spin MO 20904

State

2. Registrar's Signature

APR 0 1 2005

31. Date filed (Month, Day, Year)

			For State		State	of Maryland	•	artment rtificate				-	giene	200	(100mg	2027
			Registrar Decedent's Name	(First, Middle,	Last)			· · · · · · · · · · · · · · · · · · ·		Journ		2. Date of De		- 00	3.	Time of Death
	Physici	an	Juana			Avila						Month	Day		ar	LO:05ª M
	/Medic		4a. Facility Name (If	B.				4b Ciby T	FOURD OF	Location of	of Dooth	March		County of D		10:054
7	Examin	er												ince		*a.l.a
			5. Social Security Nu		Drive,	7. Age (In yrs. la	st hirthday	If Under		tsvil If Under		8 Date of Bir				(State or Foreign
	Funeral Director		None	inbei c	1 □ M 2 □ KF	83	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Aug • 25	y Year)	21 Н	Country) ondur	as
			Usual Residence of [Decedent			-					ing.				
	ow III		10a. State	10b. County		10c. City	Town or Le	ocation							10d. li	nside City Limits
	Man	ţō	Maryland	Prince	e George	's		Hyatt	svi	lle					1	I∏Yes 2%∑No
	1 the	Director	10e. Street and Num				·	10f. Zip					10g. Citiz	zen of What	Country?	
	3a o		1307 Me	rrimac	Drive,	#3		20	783				Н	ondur	as	
	ms 2	Funeral	11. Marital Status		12. Was Dec	edent Ever in U.S	5. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No)· 1	4. Race - A		ndian,
G	or Ite	표	1 Never Marrie	d 2 Marrie		2 XNo	1		•			Rican, etc.)		Black, W	/hite, etc.	
Ö	urs a	Ď	3 🖾 Widowed 4	Divorced	If Yes, G Year or I			1 M Yes 2	No.	Specify:	поп	duran	_	Specify:	White	2
21215-0036	be filad within 72 hours after death with the Maryland hal Hyglene. Id other than "naturel", or items 23a or 28a-f show event. I'm Medical Evarifier must be notified at	Completed	/Spacif	15. Decedent's	Education grade completed	1	16a. Dece	dent's Usual	Occupa	ation	t of work	ina	16b. Kir	d of Busine	ss/Industr	у
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S	e filad within al Hygiene. I other than '	NO.	6			`	Ho	memake	er				Ow	n Hom	e	
þ	al Hy loth	Be (17. Father's Name (F	First, Middle, La	ist)					18. Mothe	er's Name	e (First, Middle,	, Maiden :	Sumame)		
/la	uld b Went rrkad rrkad	10	Mariano	Avila						A	liji	a Nunez	Z			
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Ĕ	Page int: If	,	1 X Burial 2 L		I⊠Removal from cify)	ISIAIO		Grande			_	005				al America
alti	mit.		21. Signature of Fun	eral Service Li	censee	,	12	2. Name and	Addres	s of Facilit	ine	Funeral				
m	Depar Depar Impor any in	10 1	MANI	RMC	CHEH	RIKTY									ng, M	1D 20901
			23a. Part1. Enter the	e disease, or o	omplications that	caused the death.	Do not en	ter the mode	of dying	g, such as	cardiac (or respiratory a	rrest,		App	proximate prval Between
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rds	quires n sign ald be											1 🗆 1	Yes 2□]No 3□	Probably	4 🗷 Unknown
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Division	I or Attending after death. Diractor: After	Certification:	2 Accident 3 Suicide	6 Could no	t be	e of Injury - At hor	ne. farm. st	reet, factory.			-	28f. Location (5	Street and	Number or	Rural Rou	ute Number.
Ο̈́	- e -	erti	4 🗌 Homicide	determin	build	ding, etc. (Specify)		,				City or Tov				
	spita ours naral filled		29a, Certifier	r Certifying	Physician: To th	e best of my know	riedge, deat	h occurred a	at the tim	e. date an	d place.	and due to the	cause(s) a	and manner	as stated	
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	To the Hospital or within 24 hours af To the Funaral D completely filled in	E	29b Signature and t	itle of certifier				29c.	License	number			29d. Date	signed (Mo	onth, Day,	Year)
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician Angle Janet Caroline /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 28 Examiner AlleGANI MEAR+ OITAL DACTEC 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖾 F 220-26-9447 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State MD. Allegany Westernport ¥¥Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Spruce 21562 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 227No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes **Ž**XNo Specify: 3₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) School System Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Carl Jonosha Adaline Coyle 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Raines/ daughter 405 Poplar St., Westernport, Maryland 04/04/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Maryland Cumberland Crematory 2005 ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 7. Wayne 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis 3 days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypernationia deligaration 1 Yes 2 No 3 Probably 4 Unknown Parkinsonism, Demention 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Obstructive pulmonary disease performed 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 1 2 Natural 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of 9 D0021488 April 3, 2005

ype. Print)
20 Dougles Avane, Conacaing, 191 21537 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Devlin M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR -4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 29 2005 ear **Physician** 6:33 рм Juanita J. Anderson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Charles 303 Bland Drive Indian Head If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Mo 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 💢 F Yrs. 216-32-7372 Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be nutified at X□Yes 2□No Directo Charles Indian Head Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code with t 5 items 23a 303 Bland Drive 20640 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Ia marked other than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bertha Wheeler Oscar B. Bledsoe 19a. Informant's Name/Relationship (Type, Print) William W. Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 ia m any injury or other traum <u>once</u>. 303 Bland Dr., Indian Head, Md. 20640 Obb. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 22. Name and Address of Facility Williams Funeral Home, P.A. 20640 4270 Hawthorne Rd., Indian Head. Md. M00668 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death ORONARY Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ANo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by RRHYTHMIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 1 Yes 2 🗷 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 RNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 29a. Certifier 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 3,30,05 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, DR RA). CAMTANI MD SCATAWAY RO CLINTON MD 32. Registrar's Signature State 2005 CHAN Registrar

			For State Registrar	State of Maryland			of Heal			iene	15	12830
	Discorded:		1. Decedent's Name (First, Middle, Last)						2. Date of Dea		Year	3. Time of Death
	Physicia /Medic	al	NASR ULLAH	ALVI					April	2 200		2310 "
4	Examin	er	4a. Facility Name (If not institution, give s	. 1		46. City, To	own, or Loca	ition of De	ath	Talk	4	
	Funeral		Memorial Hosp 5. Social Security Number 6. Sex		birthday)	If Under 1		nder 24 H				e (State or Foreign
	Funeral Director			M 2□F 80	Yrs.	Months	Days Ho	urs Mi	June 24			ndia
	D .		Usual Residence of Decedent 10a, State 10b, County	10c. City, 7	own or Lo	cation					10d	. Inside City Limits
	fanyla shov	ō	MD Talb		OWN 01 20		ston				100	1 Ty Yes 2 □ No
	the A	rect	10e. Street and Number			10f. Zip C	ode		1	0g. Citizen of Wh	hat Country	n
	h with	io le	351 North Washi	ngton Street			2	1601		United	Sta	tes
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23e or 28e-f show ont, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 21 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mro If Yes, Give Year or Dates:		Vas Decede Yes, specif		ic Origin? exican, Pu	(Specify Yes or No- erto Rican, etc.)		- American , White, etc Asi	.
2-0	72 hours natural',	eted	15. Decedent's Educ (Specify only highest grade		6a. Deced	lent's Usual kind of work	Occupation done during retired)	most of v	vorking	16b. Kind of Bus	iness/Indus	stry
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au	id be ental ked o	To Be	Fagir Ullah				A	mana	at Bibi			
Maryland	shou and M s mar umat	۲	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailin	g Address (Rural Route Number	City or Town, S	tate, Zip Co	ode)
Σ	and 2 salth a n 27 i		Hamidan Begum/S					hing	ton St.			
Baltimore,	of He of He or oth		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ R	cam	e of Dispos etery, cren	sition (Name natory or oth	of er place)			20c. Location - C	ity or Town	n, State
Ë	: Pag tment tant:		* 4 □ Donation 5 □ Other (Specify)	Muha		Buk						burg,MD
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risi	Attendi death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	e, farm, str				28f. Location (S	treet and Number	r or Rural F	Route Number,
Ö	tel or safter sa all Dire	Certification:	4 Homicide determined	building, etc. (Specify)					City or Tow	i, State)		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 12 Certifying Physical Exami	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred a vestigation,	t the time, da n my opinior	ate and pla n, death or	ace, and due to the courred at the time, o	ause(s) and man late and place, ar	ner as state nd due to th	ed. ne cause(s)
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			30. Name and address of person who co				LINE	LE		70,2	1601	
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			For State Registrar		State	of Ma	arylan	•	artmen rtificat				lental Hy	giene Reg. No.	0.0	Trong	1281	3 1
I	Physici /Medic	an	1. Decedent's Name (First, Mi Marjorie And										2. Date of De Month March	28		Ž005	3. Time of £ 2:15	PM
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	Funeral Director		579-44-5611 Usual Residence of Decedent	1	□ M 2 ⊠ F	_	71	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Dec. 1	iy, Year) 9, 19	33	Wash	ice (State or y) ingtor	n, DC
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	th with t 23a or 2 ust be n	rai Dir	10e. Street and Number 107 Spring Va	lle	y Drive	9			10f. Zip	Code	21403	3		10g. Citiz	U.S.	hat Count	ry?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic svent, the Medical Evantral must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 201 3 Widowed 4 Divorce		12. Was De Armed I 1 Tyes If Yes, G Year or	Forces? 2 XX Sive		1	Was Deced if Yes, spec 1 Yes		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)			- America k, White, e Whi	tc.	
Baltimore, Maryland 21215-0036	within 72 h lene. r than "natu	ompleted	15. Dece (Specify only hig Elementary/Secondary (0-1) 12	hest gra			+)		dent's Usua kind of wo DO NOT us	rk done d se retired	during mos ()	et of worki	ing			siness/Indi		
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, Mar	and 2 she alth and 27 is m		Paul Au/husba		Type, Print)				-				al Route Numb 7e Ann	-			1403	
imore	Pages 1 and of He ant: If item		20a. Method of Disposition → Burial 2 □ Crematio • 4 □ Donation 5 □ Other			n State	0	lace of Dispo emetery, crei dar Hi	matory or o	ther plac		4/4/2	Date 2005			city or Tow	_{m, State} ryland	i
Balt	permit. Departr Imports any inji		21. Signatur Ineral Serv	E	, N	il	Ue.	2 1	47 Du	ike c	of Glo	ouces	n M. T ster St	. Anr				401
8760,	Physician and // / / / / / / / / / / / / / / / / /	icai Examiner	23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or comist only	b. Due to	o (or as a	a consequ	S (P)	(-VI)	le of dyin	g, such as	cardiac o	or respiratory a	rrest,			Approximate interval Betwo	een
P.O. Box 687	ath certifi ttending or use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{PNo} \) 9 \(\text{Unknown} \)			birth gnant at	of pregna 2 □ Fetal time of de	Ideath 3□	□Ectopic pr □ Other (sp					2	3d. Date Mon	of deliver	,	ear
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant cond	itions o	contributing to	death bu	ut not resi	ulting in the u	nderlying o	ause give	en in Part I		23e. Did 1				cause of dea	
al Records,		Completed											24a. Was auto perfo 1 Yes		pr de	rior to com eath?	sy findings av pletion of cau	
Division of Vital	ding Phys I. After this funeral di	Certification: To Be	3 Suicide 6 □ Co	ding stigation	28a. Date (Mo	ce of Inju	Year)	ER/Outpatier 28b. Time o Injury	f 2	8c. Injury Work	er: 4□ Nu	ursing Ho	me 5 Resi 28d. Describe 28f. Location (City or To	dence 6 how injury	occurre	d	Route Numbe	Θ <i>r</i> ,
נ	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certi (Check only one) 2 Medi	ying Ph ai Exar	njińer: On the	he best of basis of	examina:	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) date and	and man	nner as sta nd due to t	ted. he cause(s)	
ı	To the within 2 To the complete	Me	29b. Signature and title of cer	rier/	vonte	M	ワ		290	C. License	944 744	15		29d. Date	signed	(Month, D	ay, Year))_00T	-
			30. Name and address of pers	(F)	nJIFIO)	50	0191	Print)	1 F	W6	4	12/	Any	140	hor	nn	
	Sta Registr	_	31. Date filed (Month, Day, Ye			Heogra	ar's Signa	ture	Son						,			

				te of Maryland / Depa	artment of He	ealth and M	ental Hygi	ene) Ex	12232
		_	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	<i></i>	funcate of D	reatn	2. Date of Death	. No:	111	3. Time of Death
	Physici	an	Theresa Marie	Boteler			Month	Day	Year	
	/Medic Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or L	ocation of Death	April	1 2 4c. County	005 of Death	3:00 A ^M
	LXAIIIII	ei	36430 Vixen Run Lane		Chaptic				Mary	1 9
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	-	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)			lace (State or Foreign
	Director		032-48-8509	47 Yrs.	Months Days	Hours Mail.	Mar. 13	1958	Mass	achusetts
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ecation				1	0d. Inside City Limits
	Maryi f sho	for	MD St. Mary's							1 ☐ Yes 2 🛣 No
	r 28a	rec	10e. Street and Number	Chaptico	10f. Zip Code		100	. Citizen of V	Vhat Coun	itry?
	h with	Funeral Director	36430 Vixen Run Lane		20621			U. :	S. A.	
	ems 3	Iner		s Decedent Ever in U.S. 13.1	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-		e - Americ	
36	s after	by Fu	1 Never Married 2 Married 1 If Y	Yes 2 ₹ No es, Give	1 ☐ Yes 2 🙀 No	Specify:		Specify		etc.
Ö	filed within 72 hours after death with the Maryland Hygiene. vther then "natural", or items 23a or 28a-f show ant, the Medicel Examiner must be notified at	q pa	3 ☐ Widowed 4 ☐ Divorced Yes	r or Dates:	dent's Usual Occupati	ion	1.10		Whi	
5	in 72 n "na /edic	Completed	(Specify only highest grade comp	leted) (Give	kind of work done du DO NOT use retired)	iring most of working	ng l'	ib. Kind of Bu	isiness/inc	dustry
212	d with giene.	om	Elementary/Secondary (0-12) Col	ege (1-4or 5+) Data	Entry Cle	rk		Dil Cor	npanv	1
멀	al Hy s other	BeC	17. Father's Name (First, Middle, Last)		1	18. Mother's Name	(First, Middle, Ma	iden Sumam	re)	
yla	Ment Ment arkec	To	Alfred Louis Perini			Carol Ann	n Dickins	on		
Maryland 21215-0036	pemist. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 271s marked other than "natural", or items 23a or 28a-f show any njury or other traumatic evant, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Prin		ng Address (Street an					
	1 and Health am 27 ther t		Robert O. Boteler, II 20a. Method of Disposition		Vixen Ru					
Baltimore,	nt of t		Burial 2 Cremation 3 Remova	IIOIII State	sition (Name of matory or other place)		4,	c. Location -		
를	it. P.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee		al Garden					ryland
B	Depermine the contract of the		Yours Bet	M00641 3	0195 Three	Bri Notch R	nsfield- d. Charl	Echols otte H	Fun.	1.Hme.,P.A. MD 20622
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not enter on each line.	er the mode of dying,	such as cardiac or	respiratory arres			Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	Pancreate Can	car					Lyear
	/Medical Examiner		Description of the control of the co	ue to (or as a consequence of):						0
		ē		ue to (or as a consequence of):					-	merel 163
	uted	Examiner	Cause (Disease or injury that initiated events	Live Mets						morths
o,	e exectan an an arial-tr	Exa	no acciding a language \ 1 and	ue to (or as a consequence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	licai	d							
9	eath certifica attending ph for use as t	Physician/Med	IF FEMALE:							
Box	attend for us	ian	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delive nth	ry Day Year
o.	the de	iysic	1 Yes 2 No 9 Unknown 9 □	Unknown	Other (specify)					
۵.	res that the de signed by the a be detached t	by Pr	Part II. Other significant conditions contributing	g to death but not resulting in the ur	nderlying cause given	in Part I.	23e. Did toba	co use contr	ibute to th	e cause of death?
rds	w requires been sig should be						1 ☐ Yes	2 N o	3 🗌 Proba	ably 4 □Unknown
Records,	law re as bee 2 sho	Completed					24a. Was an	24b. V	Vere autop	sy findings available
	The lay ate has page 2	Com					autopsy performe 1 Yes 2	da d	leath?	npletion of cause of
/ita	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one)			
Division of Vital	Attending Physician: r death. ector: After this certifici	J.	1 ☐ Yes 2 No Hospital	1 Inpatient 2 EH/Outpatien		4 ☐ Nursing Hom)
UQ.	ding Phy th. After this funeral o	ion	1 Natural 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	at 2. as 2No	8d. Describe how	injury occurr	ed	
18	f or Attencatter death	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, str			8f. Location (Stree	at and Numbe	er or Rural	Route Number
2	Dirte	Certification:	4 Homicide	building, etc. (Specify)	,,		City or Town, S			
	Hospitaf 14 hours a Funeral tely filled		29a. Certifier Certifying Physician:	To the best of my knowledge, death	occurred at the time	, date and place, a	nd due to the caus	e(s) and ma	nner as sta	ated.
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	ledical	one) 2 Medical Examiner: On	the basis of examination and/or in manner stated.	estigation, in my opir	nion, death occurre	d at the time, date	and place, a	ind due to	the cause(s)
	To To corr	Σ	29b. Signature and title of codifier	6/20	29c. License r			Date signed		
1			- Classe	1-28/1-	D:	59061		April	1, 20	
1	Ω μ		30. Name and address of person who complete	cause of death (item/23a) (Type,	Print)	-1 D1 C	.dr. 010	Prince	e Fre	derick,
	Sta	te	31. Date filed (Month, Day, Year)	32. Redistrar's Signature	LIU HOSPIT	al Kd. St	ite ZIZ	MU 200	0/8	
	Registra		APR 0 2 2005	d cause of death (Item 23a) (Type, M) 32. Resistrar's Signature	DANG!					
			7 1 1 V	-						

	ın	Decedent's Name (First, Middle, Last SUSAN GONSALVES	BETTS				2. Date of De Month April	8, Day 2005	ear 0725 A	
/Medic Examin		4a. Facility Name (If not institution, give 8907 Tumar Drive	street and number)		4b. City, Tow Columb	n, or Location of E	Death	4c. County of Howard		
uneral irector		5. Social Security Number 6. Se 216-74-3471	x 7. Age □ M 2∑XF	(In yrs. last birthday 47 Yrs.	If Under 1 Ye Months Da		Min. 8. Date of Birl	th 9 9 1 9 57 M	Birthplace (State or Foreig Country) aryland	
fshow	ior	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (George's	10c. City, Town or L Beltsvi					10d. Inside City Limit	
3a or 28e	Funeral Director	10e. Street and Number 4502 Yates Road			10f. Zip Cod	0705		10g. Citizen of Wha Untied S	•	
el', or Items 2 Exerciter na	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent If Yes, specify C		? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Black, V	American Indian, White, etc. White	
10a. State 10b. County 10c. City, Town or Location Beltsville 10a. State 10b. County Beltsville 10b. County Beltsville 10c. City, Town or Location 10d. Zip Code 20 20 20 10d. Zip Code 20							-	16b. Kind of Busin	ess/Industry	
rked othe	To Be C	17. Father's Name (First, Middle, Last) Arthur Paul Gonsal	lves				Nam <i>e (First, Middle,</i> cia Ann Ba			
a 27 is ma er treuma		19a. Informant's Name/Relationship (T) Michael P. Roth —s	ype, Print) 30N	19b. Maii 1120	ing Address <i>(Str</i> 1 Caucer	eet and Number of S Ridge	or Rural Route Number Court Lau	er, City or Town, Starel, Mary.	nte, Zip Code) land 20723	
ent: If iten ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)		20b. Place of Disp cemetery, cre Metropo.	matani ar other	nlacal	Date 4/10/2005	20c. Location - City Alexandr	y or Town, State ia, Virginia	
Import eny inj		21. Signature of Funeral Service Licens	Turet	44	100 Powo	er Mill	dt Funera Road Belts	sville, Ma	.A. aryland 2070	
physician and the burial-transit the burial-transit	Exa	if any, leading to immediate cause. Enter Underlying	a. Pneumonia Due to (or as a b. Due to (or as a c.						Approximate Interval Between Onset and Death	
shys the	Physician/Medical E	iysician/Medical Ex	in the past 12 months?	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death 3	⊒Ectopic pregna ⊒ Other (specify			23d. Date of Month	delivery Day Year
as as	nysic	Part II. Other significant conditions continuing to death but not resulting in the underlying cause given in Part I.						. Did tobacco use contribute to the cause of d		
igned by the attending I be detached for use as	by	9-3Unknown Part II. Other significant conditions co	ntributing to death bu	t not resulting in the i	underlying cause	given in Part I.		′es 2□No 3□	Probably 4 Unknow	
been signed by the attending I should be detached for use as	by		ntributing to death bu	t not resulting in the i	underlying cause	given in Part I.	1 ☐ Y	an 24b. Were	e autopsy findings availab to completion of cause of h?	
is certificate has been signed by the attending I director, page 2 should be detached for use as	To Be Completed by	Part II. Other significant conditions co	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day	ot 2□ER/Outpatie	nt 3 DOA	26. Place of	24a. Was autop performance of the control of the co	an 24b. Wern prior med? deat 2 \(\text{No} \) No 1 \(\text{No} \)	e autopsy findings availab to completion of cause of h? Yes 2 \(\sumbole \) No	
is certificate has been signed by the attending I director, page 2 should be detached for use as	To Be Completed by	Part II. Other significant conditions co 25. Was case referred to medical examiner? 1 ★ Yes 2 No 27. Manner of Death 1 ★ Natural 5 Pending	Hospital: 1 □ Inpatien 28a. Date of Injury (Month, Day	ot 2 □ ER/Outpatie (Year) 28b. Time (Injury) ry - At home, farm, st	nt 3 DOA	26. Place of Other: 4 Nursin Nury at Vork?	24a. Was autop performent of the control of the con	an symmed? 24b. Warnersymed? 2 \(\text{No} \) 1	e autopsy findings availab to completion of cause of h? Yes 2 No	
Fundatal Directors. After this certificate has been signed by the attending it left filled in by the funeral director, page 2 should be detached for use as	edical Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phy	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day)	ot 2 ER/Outpatie (Year) 28b. Time of Injury ry - At home, farm, st (Specify) f my knowledge, dea examination and/or in	nt 3 DOA of 28c. In M 1 reet, factory, offi	26. Place of Other: 4 Nursin Nursin Nursin Yes 2 No ce	24a. Was autopoperform of the control of the contro	an 24b. Wern sy prior deat 2 No 1 X ne) lence 6 X Other (3 now injury occurred or n, State)	e autopsy findings available to completion of cause of h? Yes 2 No Specify) at SCen or Rural Route Number,	
he Funded Birectors. After this certificate has been signed by the attending the funded by the funded for use as pletely filled in by the fundral director, page 2 should be detached for use as	ledical Certification; To Be Completed by	25. Was case referred to medical examiner? 1\$\overline{\chi}\$Yes 2 \subseteq No 27. Manner of Death 1\$\overline{\chi}\$Natural 5 \subseteq Pending investigation 3 \subseteq Suicide 6 \subseteq Could not be determined 29a. Certifier (Check only 2\$\overline{\chi}\$Medical Exami	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injur building, etc. reician: To the best of iner: On the basis of	ot 2 ER/Outpatie (Year) 28b. Time of Injury ry - At home, farm, st (Specify) f my knowledge, dea examination and/or in	nt 3 DOA of 28c. In M 1 reet, factory, offith occurred at the occurred at the overstigation, in m 29c. Lice	26. Place of Other: 4 Nursin Nursin Nursin Yes 2 No ce	24a. Was autop performent of the control of the con	an 24b. Wern sy prior deat 2 No 1 X ne) lence 6 X Other (3 now injury occurred or n, State)	e e autopsy findings available to completion of cause of h? Yes 2 No Specify) at SCen If Rural Route Number, If as stated, due to the cause(s)	

			1 - For State Registrar	State of M	Maryland / Do	epartment Certificate			d Mental Hy	giene	05	12834
	Physici /Medi	cal		BOWENS		J 11 02 7			2. Date of Di Month	Day 27	Year	3. Time of Death 05 44A
	Examir Funeral	ner	4a. Facility Name (If not institution, gunneral property of March 1997) 5. Social Security Number 6	HEYLAND M	r) BOICAL CUNT ge (In yrs. last birth	day) If Under 1	CT//	M TRE	=,MD	4c. Count		ace (State or Foreign
	Director		213-68-5790 Usual Residence of Decedent	1□M 2X1F	49 Y	S.	Days H	Hours I	Mar. 1	rth ay, Year) 4,1 956	Ma	ryland
	r 28a-f show	Director	MD Anne 10e. Street and Number	Arundel	10c. City, Town	Sevel				10g. Citizen of		d. Inside City Limits 1 □ Yes 2 □ No ry?
9036	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28a-f show ha Madical Examinar must be notified at	by Funerai	8347 Flin 11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces	t Ever in U.S. ?	13. Was Deceder If Yes, specify	t of Hispa Cuban, N		? (Specify Yes or Nuerto Rican, etc.)	o- 14. Ra Bla	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black	
d 21215-0036	s should be filed within 72 hours and Mental Hygiene. is marked other than "netural", aumatic event, the Medical Ex-	e Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, La	grade completed) College (1-4o	(5+)	Decedent's Usual (Give kind of work ife. DO NOT use Self-en	done durir retired)	ng most of yed	working Name (First, Middle		Care	Provider
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, I	To Be	Stanley E. 19a. Informant's Name/Relationship	-		Mailing Address (S			h H. Let		State, Zip (Code)
	5 4 1 3		Charles Bowe 20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removal from Stat	20b. Place of D	Disposition (Name crematory or othe	of r place)		Ct., Se	20c. Location	City or Tow	vn, State
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		'4 □ Donation 5 □ Other (Spe 21. Signature of Filheral Service Lice		Gl/en\H	22. Name and	Address of	f Facility	2/05 Snowden St., Roo	Funera	1 Ho	me, P.A.
8760,	Physician /Medical Examiner	ai Examiner	23a. Part 1. Enter the disease, of or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, having to lining diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c.	ed the death. Do not line. PA H H S s a consequence of the same sequence <i>B</i>	of dying, so	uch as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death	
.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 □ Fetal death at time of death	3 ☐ Ectopic preg					te of delivery	y Day Year
<u>α</u>	quires that I n signed by uld be deta	by	Part II. Dther significant conditions	s contributing to death	but not resulting in t	he underlying cau	se given in	Part I.	23e. Did 1	tobacco use con	ribute to the	
Records,		Completed							24a. Was auto perfo	psy ormed?	prior to com: death?	sy findings available pletion of cause of
Division of Vital	ng Physicien: fter this certific neral director,	Certification; To Be (25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could no	he	ury 28b. Tin ay Year) Inju	ne of 28c	Other: Injury at Work? 1 Yes			idence 6 Oth	red	
Divi	Hospital or Attendir 14 hours after death. Funeral Director: A tely filled in by the fu		4 Homicide determine	280. Place of I	njury - At home, farm			date and n	City or To			
)	To the within 2 To the comple	Medical	29b. Signature and title of certifier	aminer: On the basis and manner s	of examination and/	or investigation, in	my opinio	on, death o	accurred at the time,	date and place, 29d. Date signe	and due to t	he cause(s) ay, Year)
_	3		30. Name and address of person wh	no completed cause of	death (Item 23a) (Ty OF MARY L	(pe, Print) HO ME	DIAL	CON	PER BA	umme	=, mo	
1	Sta Registi		31. Date filed (Month, Day, Year) APR 01	2005 32 Regis	Tear's Signature	perle						

			1- State of Maryland / Dep	artment of Health and lartificate of Death	Mental Hygie	ZUU5 12835
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		MICHAEL LEE BURGESS		March 24	Day 2005 01:35 P.M
>	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
			Shady Grove Adventist Hospital	Rockville		Montgomery County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country)
	Director		216-48-8482 1XM 2 F 57 Yrs.		Mar.21,	1948 Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Manyl f sho	5	MD Montgomery Sil	Tor Charles		1 ☐ Yes 2 ☐ No
	the 128a-	Director	10e. Street and Number	ver Spring	10a	. Citizen of What Country?
	3a or	Ö	203 Stubblefield Way	20905	-	U.S.A.
	ms 2	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		14. Race - American Indian,
<u>ن</u>	or ite	Fur	1 Never Married 2 Married 1 XYes 2 No		o Rican, etc.)	Bfack, White, etc.
03	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 68-71	1 ☐ Yes 2 ☒ No Specify:		Specify: Black
2	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ant, Ite Mudical Examinar must be nutified at	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of wo	rking 16	b. Kind of Business/Industry
2	vithin ne. han '	шр	Elementary/Secondary (0-12) Colfege (1-4or 5+)	DO NOT use retired)		NTCH
N N	lled v lygie ther t	ပိ	12th 17. Father's Name (First, Middle, Last)	Custodian	ne (First, Middle, Ma	NIST
Maryland 21215-0036	ad of	Ве	Charles Lee Burgess		ona M. Ga	
2	should od Me mark matic	2				ity or Town, State, Zip Code) 20905
\leq	Ith ar 27 is r trau		Regina Burgess (Cousin) 203	Stubblefield	Jav. Silv	zer Spring. MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, Ite Modeal Examiner must be notified at once.		20h Place of Disposition	ocition (Name of		c. Location - City or Town, State
Ë	Page on: T		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	omatory or other place) Cemetery on Forest 4/4	1/05 E	Baltimore, MD
att	mit. partm porta / inju					neral Home, P.A.
m	Pe In Pe	19				ville, MD 20850
			23a. Part1. Enter the disease, or complications that caused the death. To not en shock, or heart failule. List only one cause on each line.	iter the mode of dying, such as cardia	or respiratory arrest	Approximate Interval Between
	Physician :	5 14	Immediate Cause (Final disease or condition	Carl merelon 1	Judna	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	STOREST PROCESS		
	LAdimine	_	Sequentially list conditions,			
	led sit	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	al-tra	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760	licate be executed physician and s the burial-transit	dical	d			
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Box	death certiff e attending id for use as	an/h	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetaf death 3	⊒Ectopic pregnancy		23d. Date of delivery
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	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or in			
	To the within 2 To tha complet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	1		VIII IIV	OCME	N	March 25, 2005
	4		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		
Y			THEVPOREMIKE	111 Penn Stree	t Baltimo	ore, Maryland 21201
	Sta		31. Date filed (Month, Day, Year) APR 01 2005	arte		
	Registr	ar	WALK AT COO? DOWN YOU WAS			

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** BURRELL 3:30 MARION C РМ MARCH 31, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3503 ROCKWAY AVENUE ANNAPOLIS ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | March 13, 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Y^{ear)} 1910Washington, DC 1 □ M 2 1 XF 95 Yrs. Director 579-60-8171 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ont: If item 27 is marked other then "naturel", or items 23a or 28e-f show 10a State 10b Counts 10c. City. Town or Location 7 is marked other then "naturel", or items 23a or 28e-f show treumetic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1√ Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Rockway Ave. 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** þ Spacify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government 4yrs. Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Clark Maria Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other treu once. Joseph Burrell / Son 1310 Edenville Dr. District Heights, MD 20a. Method of Disposition

1 Peurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Lincoln Memorial Cem. 4-7-05 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MARSHALL®S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause It is a sequential to the cause it is Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injurthat initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Breast Cancer 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural Injury 5 Pending death. 1 🗌 Yes investigation 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical To the I and manner stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DUGUEY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Weiss 139 Old Solomon Islands Rd. Annapolis , MD 31. Date filed (Month, Day, Year)

ADR 0 4 2005 State Registrar

State of Maryland / Department of Health and Mental Hygien@ [] [] 5 12838 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** MARCH 30, BARBER HIAWATHA Η. 12:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FT. WASHINGTON HOSPITAL FT. WASHINGTON PRINCE GEORGE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day,) 9-22-31 9. Birthplace (State or Foreign Sex XXM 2□F **Funeral** Year) Months Days Hours Min. Yrs. NORTH CAROLINA 241-36-2959 73 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or itams 23e or 28e-1 show other traumatic event, the Medical Evantinar must be notified at XXYes 2 No Director FT. WASHINGTON MARYLAND PRINCE GEORGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 INVERNESS LANE 20744 S. Α. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other then "natural", or Ital 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2\(\times \text{No}\) Specify: Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ YEARS ACCOUNTANT U.S.NRC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY B. BARBER PEARLIE FUNDERBURK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VYLLORYA A. EVANS-FRIEND 732 - 3RD ST., S. W. WASHINGTON, DC 20024 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If its
eny injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MD. STATE VET. CEM. 4-8-05 CHELTENHAM, MD 21. Signature of Euneral Service Licensee PINCKNEY SPANGEER FUNERAL HOME heo 524 - 8TH ST., N. E. WASH., DC 20002 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death YEARS Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by leted 1 ☐ Yes 2 ☐ No 3 X Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Comple 24a Wasan has 1 Yes 2**X** No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 XNo 1 ☐ Inpatient 2 X ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1**XX**Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Sompletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ent Men M.D D32800 MARCH 30, 2005 FT WASHINGTON MD 30. Name and address of person who completed cause of death (I/F m 23a) (Type, Print) H. HERBERT WASHINGTON, M. D. 11701 LIVINGSTON RD. STE.205 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 4 2005

DHMH 17 Rev 1/2001

Registrar

T.		State of Maryland / Department of Health and Menta 1- State Registrar Certificate of Death		05 2839
			e of Death	3. Time of Death
Physicia		Elizabeth Anne Bednar $\mathcal{M}_{\alpha}^{Mo}$		005 12:00 PM
/Medica		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		ty of Death
		Doctor's Community Hospital Lanham		nce George's
Funeral		5. Social Security Number 170-28-2029 6. Sex 7. Age (In yrs. last birthday) 170-28-2029 7. Age (In yrs. last birthday) 170-28-2029 1	e of Birth nth, Day, Year)	Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	. 26, 1930	Pennsylvania
/land		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Mar a-f st	ģ	Maryland Prince George's New Carrollton		1 🙀 Yes 2 🗆 No
or 28	ire.	10e. Street and Number 10f. Zip Code	10g. Citizen o	f What Country?
22 beth	ra	8402 Longfellow Street 20784		USA
Ser de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent U.S. Armed Forces? 1 □ Yes 2 ☒ No	s or No- etc.) 14. Ra	ace - American Indian, ack, White, etc.
)36 18 all or	by	3 Widowed 4 Divorced Specify: 1 Yes 2 No Specify:	Spec	^{ify:} White
5-0036 72 hours at neutural; or	Completed by Funeral Director	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of	Business/Industry
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Maryland of 2 should be file the and Mental Hy 27 is marked oth the traumatic avent	0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route		
		Thomas B. Bednar (Husband) 8402 Longfellow Street, N		
Baltimore, sermit. Pages 1 ar Department of the mportant: If them my injury or other bace.		20a. Method of Disposition 20b. Place of Disposition (Name of Date		- City or Town, State
Page ment in a contract in a c		'4 Donation 5 Other (Specify) Chesapeake Crematory 4/6/2005	Beltsv	ville, MD
Balt Bernit. Depart import import once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/	Hale Funer	al Home
□	4	Patricia Latimore 9013 Annapolis Road, I		
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirations shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
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Division To the Hospital or Attending Within 24 hours after death. To the Funeral Diractor: After completely filled in by the funeral		29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	to the cause(s) and m time, date and place,	anner as stated. and due to the cause(s)
Totl Totl comp	3	29b. Signature and title of certifier 29c. License number	29d. Date signe	ed (Month, Day, Year)
5		D0050951	411	100
J		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REVA S. CILL GSIO KENILWORTH AVE RIVER	DALE n	1D 20737
State Registrar	2	31 Date filed (Month, Day, Year) 32. Registrar's Signature		

			1- For State of Maryland / Departm Registrar Certific	ent of Health and Neate of Death	lental Hygie	ne No. 005	12840
			Decedent's Name (First, Middle, Last)		2. Date of Death	1102 - 0	3. Time of Death
	Physici		Dorothy Butt		Month March 29	Day Year	9:02am ^M
	/Medi Examir			City, Town, or Location of Death	THAT CIT 25	4c. County of Death	9.02am
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	Funeral			thersburg Inder 1 Year If Under 24 Hrs. This Days Hours Min.	8. Date of Birth (Month, Day, Ye		lace (State or Foreign
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Maryland	2 s s			ress (Street and Number or Run			
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Baltimore,	permit. Pages 1 Department of H Important: If its any injury or otl once.		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State cemetery, crematory	or other place)		c. Location - City or To	wn, State
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	tha hin 2 tha mplet	Med	and manner stated.				
				29c. License number		Date signed (Month, E	
•	5		and the second of the second	204115	100	archo	17,2005
			30. Name and address of person who completed cause of death (Item 28a) (Type, Print), ROBERT BIKS (LBACK, MIX)	60 A 17419000	LAVEN!	12 man	>
	Sta	to	24 Date (iled (Month Day Yoar) 22 Physiotrade Signature		mede, oll	NOX (y
	Registr		MAR 31 2005 Acres to Appel				

Physician /Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

items 23e or 28e-f show trer roust be notified at

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permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "netun any injury or other treumatic event, Item Medical ADRE.

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

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ted by Pl	Part II. Other significant conditions of	ontributing to death but not res	culting in the Onderly)	ing cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
Complet	Disease				24a. Was an autopsy performed	
Be	25. Was case referred to medical examiner?				eath (Check only one)	
ဂ္	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
	27. Manner of Death 1- Natural 5 Pending 2 Accident investigation		28b. Time ot Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fa (y)	ctory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
Medical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knoniner: On the basis of examination and manner stated.	owledge, death occur ition and/or investiga	rred at the time, date and plac ation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
Ä	29b. Signature and title of certifier	rallen		29c. License number		Date signed (Month, Day, Year)

11119 Rockville Pike, #401, Rockville MD 20852

State Registrar

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32. Registrar's Signature

Gul Chablani, M. D.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** March 23, 12:50 P.M 2005 Goldy O. Blum /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 95 yrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🗓 F 579-01-0099 1909 Russia Director 30, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Modical Examinar must be notified at 1√2 Yes 2 □ No Maryland Prince Georges Chillum Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 828 Thurman Avenue 20783 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If them 27 is marked other han "natural, or the any injury or other traumatic svent, its Maximal Examina. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Paper Company 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Abraham Goracoff Frieda Lutzet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Mill Race Drive, Martinsburg, W. Virginia 25401 Maurice A. Goracoff/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/28/2005 * 4 ☐Donation 5 ☐ Other (Specify) Mount Lebanon Adelphi, Maryland 21. Signature of Funeral Service I 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the sath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory failure /Medical Due to (or as a consequence of): Examiner Sersis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed the burial-transit Aspiration Pneumonia and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ding physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy the atter Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 XUnknown Atrial Fibrillation Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No this certificate 1 Yes if or Attending Physician: atter death. Director: After this certifica funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nopatient 2 ER/Outpatient 3 DOA P 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check of 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number 56147 MARCH 23, 2005 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Carroll Avenue, # 205, TAKOMA Park, Maryland 20912 Dr. Nasreen Kango 31. Date filed (MoMAR 32. Fegistrar's Signature 2005 State APURA Registrar

	1 - For State Registrar		•	epartment of H Certificate of I		•	Reg. No.	nne	10010
	Negistrar Necedent's Name (First, Middle, L.	.ast)				2. Date of De	ath to	1 U D -	3. Time of Death
n al	Mary Lee Bowden					March	30, Day 20	005 ^{Year}	12:30 AM
er	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death	1	4c. Cou	unty of Death	1
	2042 Hermitage H			Gambrill				e Arun	
	5. Social Security Number 6. 239-34-9708 Usual Residence of Decedent	Sex 7. Ag	78 Yr	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 02/09/1	927	Nort	nplace (State or Foreign Intry) h Carolina
	10a. State 10b. County		10c. City, Town o	or Location					10d. Inside City Limits
Director	Maryland Prince	Georges	Bowie						1∭Yes 2☐No
	10e. Street and Number 3909 New Haven C	Court C-11		10f. Zip Code 20716			USA	of What Cou	untry?
	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of H	ispanic Origin? (S	pecify Yes or No	- 14.	Race - Amer	
,	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 💢 I If Yes, Give	No	If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	in, Mexican, Puert	o Rican, etc.)		Black, White	
	3 X Widowed 4 □ Divorced	Year or Dates:	1 10 0					, BT	ack
	15. Decedent's (Specify only highest g	rade completed)		ecedent's Usual Occup Give kind of work done of ife. DO NOT use retired	during most of wor	king	New Yo	of Business/Ir ork	ndustry
•	Elementary/Secondary (0-12)	College (1-4or 5		al Worker			Urban	Leagu	e
)	17. Father's Name (First, Middle, Las	st)			18. Mother's Nan	•	Maiden Sur	mame)	
2	Claude Pompy	(T 5111	1	4-7	Maggie l		- 0: -		in Ondal
	19a. Informant's Name/Relationship Doreen Gail Bowd	len Bydume/		Mailing Address <i>(Str</i> eet) 2 Hermitag				_	
-	Daught 20a. Method of Disposition	_	20b. Place of D	isposition (Name of		Date Ga		ion - City or T	
	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			crematory or other place Lakemont 11 Gardens	1	2/2005	Davids	sonvil	le, MD
	21. Signature of Funeral Service Lic	ensee		22. Name and Address 16000 Anna	ss of Facility Rol	bert E.	Evans	Funer	
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused by one cause on each li	the death. Do no	t enter the mode of dyin	g, such as cardiac	or respiratory a	rrest.		Approximate
- 11									Interval Between
Ш	Immediate Cause (Final disease or condition	Metasta	tic Cance	er		,			
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Medical Certification; To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to minitudiate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Lung Ca) Due to (or as c. Due to (or as d. Due to (or as	tic Cance a consequence of ncer a consequence of a consequence a consequ	atient 3 DOA Other (specify) at the underlying cause give be underlying cause give give be underlying cause give give give give give give give giv	en in Part I. 26. Place of Dea er: 4 \(\text{Nursing H} \) y at k? Yes 2 \(\text{No} \) ne, date and place pinion, death occu	23e. Did t 1	obacco use of Yes 2 \(\text{N} \) N an osy one) dence 6 \(\text{X} \) now injury och one) cause(s) and date and pla 29d. Date sign	Month contribute to 3 Pro 4b. Were aut prior to oc death? 1 Yes Courred courred d manner as toe, and due to	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death? The cause of de

State Registrar

MAR 3 1 2005



State of Maryland / Department of Health and Mental Hygiene, 2844 Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** MARCH CHESTER 2Š 9:30 A M JOHN ALBERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY DERWOOD 19651 MUNCASTER ROAD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1**℃**M 2□F 80 Yrs. 155-16-4196 July 18 1924 Massachusetts **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location Show 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and it if item 27 is marked other than "natural", or items 23a or 28a-f show and it is the control of the control in a hygical Equ., it as must be notified at uny or other traumatic event, it a hydical Equ., it as must be notified at 1 ☐ Yes 2 ☐ No Derwood Director Montgomery Md. 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 20855 19651 Muncaster Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 WWII Specify: Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) County Police Motorcycle Mechanic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Unknown Chester Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1524 Church Street, Baltimore, Md. 21226 Regina Boston/Stepdaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or once. 1

Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 4/2/05 Cumberland, Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home mure her 20882 P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 30 min. Physician Acute Coronary Insufficiency /Medical Due to (or as a consequence of) Examiner 4 months Coronary Artery Disease Sequentially list conditions, for y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed use as the burial-tran ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death certificate has been signed I fector, page 2 should be det Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2. No 1 ☐ Yes or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide o the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 30, 2005 evett Marin D 47682 10t1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 Olney-Sandy Spring Road, Olney, Md. Bennett Morrison, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 01 APR Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April **Physician** JAMES MARVIN COMER 10 2005 4:00 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1031 Priestford Road Harford Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**∑**M 2□F Yrs. Director 214-36-8572 62 5/8/1942 Maryland Usual Residence of Deceden the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10h Count 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Harford Street Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 1031 Priestford Road 21154 USA Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ₩o If Yes, Give Black, White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Owner Construction 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Andrew Comer Nola May Ball 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is in any injury or other traum once. Grace Ann Comer/Wife 1031 Priestford Road, Street, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 4/15/2005 Falliston MD 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final End-Stage Remal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner burial-transit be executed Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Diabetes Unecatrollad 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Compl autopsy performed? 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours at To the Funeral D 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D35012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Bel Air, Md. 21014 2 No 1-12 Lynchmo J. Kevin 31. Date filed (Month, Day, Year) State APR 15 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ME 201 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:05PM MARGARET MARY COOKSEY 2005 APRIL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES CHARLES COUNTY NURSING & REHAB PLATA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Yrs. MAR.14,1928 MARYLAND Director 220-38-1225 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23e or 28a-f show the Medical Examirer must be notified at 1 Yes 2 No Director LA PLATA MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 JEFFERSON STREET U.S.A. 112 THOMAS Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b.⊀(ind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "na any injury or other treumatic event, Ite Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES CLERK GIANT FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUTHER CLEVELAND HICKS, SR. CLARRISIA MARGARET EDWARDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22485 6361 JAMES MADISON PKWY., KĮNG GEORGE, VĀ BRENDA PLANAS-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ↑ Purial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEMORIAL GDNS. 4-7-05 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, PA 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20646 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CIRRHOSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 210 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 28a. Date of Injury (Month, Day Year) the funeral To the Hospital or Attending PI within 24 hours after death.
To the Funerel Director: After th completely filled in by the funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number

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P.O. Box 68760.

Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

cur

d address of person who completed cause of death (Item 23a) (Type, Print) 32. Pegistrar's Signature

102 PAULMEllow CT

april

ASHVINKUMAR 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 7 per In 8842 4-15-05 vt.

			For State Registrar	State	f Maryland		artmen rtificate					iene •g. No. 2 ()	17 6	1001.7
			Decedent's Name (First, Middle, L.)	ast)							2. Date of Deat	h	المناط	3. Time of Death
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	/Medic		4a. Facility Name (If not institution, gi				4b. City.	Town, or	Location of	of Death	TIPLII	4c. County		
	Examin	er	St. Vincent Car				Em	mits	huro			Fred	eric	k
	Funeral			Sex	7. Age (InQA last	birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign ntry)
	Director		022-40-9104	1□M 2⊠F	94	Yrs.	Months	Days	Hours		(Month, Day, ept. 22			ntry) cginia
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	r dea	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U.S. orces?	13.	Was Deced	lent of His	spanic Ori	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		e - Ameri k, White	can Indian, , etc.
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	Physici /Medic	al		ran			4h Cih.	Tour or	Logation		2. Date of Dea Month April	Day 1,	2005		A M
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	Funeral Director		5. Social Security Number 6. S 070-24-2019 Usual Residence of Decedent	ex 7. □M 2M F	Age (In yrs. Ia	st birthday) Yrs.	Months	1 Year Days	Hours	Min.	8. Date of Birt (Month, Da Nov • 15	, 1923	New New	nplace (State untry) York	or Foreign
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	3a or 2	i Dire	10e. Street and Number 2050 Pawlet Driv	e			10f. Zip	Code 114				10g. Citizen USA	of What Co	untry?	
336	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23e or 28e-f show injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at e.g.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? M∑No		Was Deced f Yes, spec	37	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Black, White	rican Indian, e, etc.	,
21215-0036	filed within 72 hou Hygiene. Ither than "nature int, the Madical E	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)		or 5+)	lite.	dent's Usua kind of wo DO NOT us emake	rk done d se retir e d)	uring most	of workir	ng		f Business/l		
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Man	d 2 sho th and 7 Is ma treuma		19a. Informant's Name/Relationship (Michael J. Sicura		n		-	,			Seven S)
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Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		' 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	~	Resu ()	22	. Name an	d Addres	s of Facility	Bea	5/2005 11 Fund Bowie,	eral H		D.	
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R	<u>(6)</u>		30 Name and address of person who	completed caus	of death (Item :	23a) (Type,	Print)	c A	Nah	#2	y h	0100	دا/اد	211	08
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			Registrar	-41		ertificate of	Death	2. Date of Death	g. No.	100	3. Time of Deat) h
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	/Medic Examin		4a. Facility Name (If not institution, give	T. Carrell se street and number)		4b. City, Town, o	r Location of Deat		4c. Co	unty of Death		
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1			Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	r Location					10d. Inside City Lin	nits
	8a-f eho	ctor	D.C.			Wa	shington				1 ∏∆ Yes 2 □	
	23a or 2	Funeral Director	10e. Street and Number 4611 Meade Street	, N.E.		10f. Zip Code	20019			n of What Cou	nuy r	
9	permit Pages 1 and 2 should be lied within 72 hours after death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if liem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examiner must be nutilised at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 2000 If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)		Race - Ameri Black, White pecify: BL		
	natur Ical	ted	15. Decedent's E (Specify only highest gr		16a. D	ecedent's Usual Occup	ation during most of wo	rkina 1	6b. Kind	of Business/Ir	ndustry	
7 7	giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	'iii	Binder	d)]]			ment (Reti	red
	snould be file nd Mental Hy imarked othe umatic event	To Be	17. Father's Name (First, Middle, Las Joseph Wash				18. Mother's Na	me (First, Middle, M Sarah Wasl				
<u>~</u>	and f		19a. Informant's Name/Relationship			lailing Address (Street					o Code)	
2	and lealth m 27 her tr		Barbara A. Carrell (I			2 47th Place, isposition (Name of	N.E. Wash			019 tion - City or T	n State	
5	Fages 1		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3	Removal from State	cemetery.	crematory or other place ivet Cemetery	April	4, 2005 W				
	artmer artmer ortant injury		' 4 ☐ Donation 5 ☐ Other (Special Signature) of Funeral Signature of Funeral Signature (Special Signature) of Funeral	197		22. Name and Addre		Rollins Fun				-
0	permit. Departr Importu any inju		1 Tout C	· Inders	2.	4339 Hunt Pl				**************************************	•	
E	Physician /Medical Examiner	ilner	23a. Park Enter the disease, or condition of the condition resulting in death) Sequentially list conditions, and the conditions of the co	one cause on each fine.	nsequence of)	otic CA			,	Dise	Approximate Interval Between Onset and Death	
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.O. DOX	To the Hospital or Attending Physician: The law requires marthe death centilical within 24 hours after death. within 24 hours after death. to the Funestal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		230	d. Date of delive Month	rery Day Year	
r (spins)	ures mat signed b	by	Part II. Other significant conditions	contributing to death but no	at resulting in th	ne underlying cause gr	ven in Part I.			contribute to	the cause of death bably 4 Honkno	-
ה ה ה	ne law rec s has beel ige 2 shou	Completed						24a. Was an autopsy perform	ed?	prior to co death?	opsy findings available ompletion of cause	able of
NI A	ifficeta or, pa	Ç	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 ath (Check only one	₽No	1 🗌 Yes	2 🔯 No	
5	ysicie s cert direct	0 8	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outp	atient 3 DOA Ott		Home 5 ☐ Reside		Other (Spec	fy)	
5 2	ding Physician; The lay h. After this certificete has funeral director, page 2	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye	ar) 28b. Tin			28d. Describe hor				
200	attendin death. ctor: Af	Certification:	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Pface of fnjury -	At home, farm		Yes 2 No	28f. Location (Str		Number or Ru	al Route Number,	
Š	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide	building, etc. (S		do a the consumer of at the fi	mo, date and place	City or Town,		nd manner ac	rtated	
	24 hos 24 hos Funda etely f	edical		iminer: On the basis of exa and manner stated.								
1	within To the	Me	29b. Signature and title of certifier	Alveta	700	29c. Licen:				signed (Month		
(6)		30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Print)	ive c	7 / Leverly		Mari 1	his a	
	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's	Signature	Coult !			/	7		

			For State Registrar	State o	f Maryland / De	partment of terrificate of			2005	1000
	Physic	ian	1. Decedent's Name (First, Midd				Dodin	2. Date of Death Month	Day Year	3. Time of Death
	/Medi Exami	cal	4a. Facility Name (If not institution	A. Crocket		4b. City. Town.	or Location of Death	March	30 2005 4c. County of Death	7:54 P M
		Ģ	Prince George	s Hospital			everly		Prince Ge	orge's
	Funeral Director		5. Social Security Number 579–82–2898	6. Sex 1⊠M 2□F	7. Age (In yrs. last birthda 28 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y March 18	(ear) 9. Birthpl	ace (State or Foreign
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or				10	Od. Inside City Limits
	h the Maryland r 28a-f show a natified at	ector	D.C.	N/A	Washing	ton, D.C.				1x∏Yes 2□No
	th with 23a or	al Dir	1509 Trinidad	d Ave. NE.		10f. Zip Code	20002	-	. Citizen of What Coun Inited State	*
336	72 hours after death with the Maryland natural', or Items 23e or 28e-f show Item Examinet must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2⊠ Mar 3 □ Widowed 4 □ Divorced	ried 1 ☐ Yes	2 ⊠ No	B. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - America Black, White, & Specify: B.	
21215-0036	C * N	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retire	pation during most of world)	king 16	b. Kind of Business/Ind	ustry
121	ifiled within Hygiene. other than rent, the Ment, the Ment, the Ment.	Соп	12th 17. Father's Name (First, Middle,			aphic Art			etail	
lanc	uld be f fental h rked of tic aver	To Be		cockett, J	r.			ne (First, Middle, Ma Lia Jackso		
Maryland	as 1 and 2 should be filed vol Health and Mental Hygies of Health and St. 1s marked other rother traumatic avent, IL		19a. Informant's Name/Relations Stacey Crockett,		19b. Ma 150	lling Address (Street 9 Trinida	and Number or Aud d Ave. NE	ral Route Number, C	ity or Town, State, Zip ogton, DC.	Code) 20002
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			position (Name of ematory or other place tion Cemet	ce) [c. Location - City or Tov	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service			22. Name and Addre	en of English PO		1 Homas	. •
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that ca	used the death. Do not each line.	nter the mode of dyin	ng, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. Due to (c	or as a consequence of):	19 Flee	d (1) a	ul Bell	4 (1)	
68760,	ficate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to minisolate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence of):					
O. Box	death certii e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bir	nt at time of death 5	□Ectopic pregnancy			23d. Date of delivery	y Day Year
rds, P	ed ed	by	Part II. Dther significant condition	ons contributing to dea	ath but not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	
tal Records,	The ate h page	e Completed	25. Was case referred to medical					24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of
of Vital	Ş	To B	examiner? 1 X Yes 2 No	Hospital: 1 Hn	patient 2 ER/Outpatie	ent 3 DOA Othe		h <i>(Check only one)</i> me 5 ☐ Residence	e 6 □Other (Specify)	
o uo	ding P h. After tl funera		27. Manner of Death 1 □ Natural 5 □ Pendin	9	Day Year) Injury	Work	at c?	28d. Describe how in		
Division	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of	f Injury - At home, farm, s g, etc. (Specify)	treet, factory, office	<i>T</i>	28f. Location (Street City or Town, St	and Number or Rural I (ate) 3 40 8 25 2	Poute Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the base Examiner: On the base and manner	est of my knowledge, dea is of examination and/or i	th occurred at the tim	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stat and place, and due to the	ed. ne cause(s)
	To th within To th compl		29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month, Da	ıy, Year)
	(1)		Theodor -	U. Ying	\	OCME		M	arch 31, 20	005
R	4		30. Name and address of person of the ODINE M. K.		&f death (Item 23a) (Type		Penn Stre	et Baltin	more, Maryl	and 21201
	Sta Registra		31. Date filed (Month, Day, Year) APR 0 4 20	2. Rec	gistrar's Signature	E)		·		

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			For State	State of M	aryland		artment o <i>tificate d</i>		ind ivie			11115	1285	5 1
			Registrar 1. Decedent's Name (First, Middle, I	actl		Cei	lineate	Dealli		2. Date of Dea	Reg. No.		3. Time of Dea	J ath
Ph	ysicia	an	Percy Elmer Col							Month March	30 Day	2005	8:30	
	/ledic amin		4a. Facility Name (If not institution, g)		4b. City, Tow	n, or Location o				County of Deat		
EX	allilli	EI	6656 Pine Top R				Hur1d	ck			Do	rcheste	r	
Fun	eral			Sex 7. Ag	ge (In yrs. la	ast birthday)	If Under 1 Ye Months Da		24 Hrs. 8	B. Date of Birt	h v. Year)	9. Birti Co	nplace (State or Fo	reign
Dire	ctor	j	215-36-2004	1 ∑ M 2□F	89	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	S	(Month, Day ept.5,	1915	Mar	yľand	
and			Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Li	imits
Maryl f sho	DA	5	Maryland Dorches	ter	Hı	ırlock							1 ☐ Yes 2 💆	√ No
3 E	Hour I	Director	10e. Street and Number				10f. Zip Coo	e			10g. Citiz	zen of What Co	untry?	
death with the Maryland	100		6656 Pine Top Ro	ad			2	21643				USA		
Z gg gg	E COM	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13. \	Was Decedent	of Hispanic Orig Cuban, Mexican	gin? (Speci	fy Yes or No-	. 1	14. Race - Ame Black, White		
or the	allin		1 Never Married 2 Married	I∏Yes 2 🕅 If Yes. Give	No		1□Yes 21X			,		Specify:	White	
within 72 hours after ene. then "natural", or Ite	al Ex	d by	3 Widowed 4 Divorced	Year or Dates:		160 Dooo	tont's Heuri Os	ougation		- 1	16h Kir	nd of Business/		
in 72	Polic	olete	15. Decedent's (Specify only highest of	grade completed)		(Give	kind of work do DO NOT use re	cupation ne during most tired)	of working	'	100.10	14 01 043111633	industry	
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d be filed ental Hygirked other	vent,	BeC	17. Father's Name (First, Middle, La.	st)				18. Mothe	r's Name (First, Middle,	Maiden :	Sumame)		
arylar should b ind Menta s marked	atic e	To E	Percy Elmer Col	lins, Sr.				Wini	nie B	aker				
ite, INIGIYIGIIG ZIZIO-0030000000000000000000000000000000000	anu.		19a. Informant's Name/Relationship				•					Town, State, Z		
e, R	thert		James P. Collins 20a. Method of Disposition	/Son	20h Pl	1			Searo			re 1997		
ages :: Fige	or of		1 XBurial 2 ☐ Cremation 3	Removal from State			sition (Name or natory or other						_	
Dallinor Dermit. Pages Department of	njury t-		' 4 □ Donation 5 □ Other (Special Signature of Funeral Service king		Uno		Cemeter		4/1/2				aryland	
Dallinore, permit. Pages 1 and Department of Healt important: If item 2	any		WALKER DO	Belle	2	Ze 10	ller Fu 6 Main	dress of Facilit Ineral I Street	dome, Eas	P. O. t New]	Box Mark	20/ et, MD	21631	
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Physic	ian		Immediate Cause (Final	Pcala.	hla	M.	1	. 1					Onset and Deat	th
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Exami	iner		Sequentially list conditions	h Coroni	ary	ITCK	ry 1) isease					30 year	45
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w requires that the death certificate be executed been signed by the attending physician and	s the			d							-			
ath certi	nse a	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Tetania augusta				2	3d. Date of deli	,	
death death	pd for	cla	in the past 12 months? 1 ☐ Yes 2 █ No	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			Ectopic pregna Other (specify					Month	Day Year	
The law requires that the death certifica ate has been signed by the attending ph	tache	Physician/Med	9 Unknown							00 5:44				
res th	pe de	þ	Part II. Other significant conditions	4.3	-	iting in the ur	nderlying cause	given in Part I.			es 2		the cause of death	
law requires tas been signe	hould	eted	Congestive			1076				-				
D 00 00	CI	ompleted		-iballatio						24a. Was a autop perfor	sy	prior to death?	topsy findings avail completion of cause	of
n: Th	director, page	O	Diahetes	Malli	tus			00.01	-1 D11 /	1 Yes	2. No	1 🗆 Yes	2€No	
sician:	Irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 🗆 E	ER/Outpatien	+ 3[] DOA	Othor		Check only o		Other (Spec	eify)	
- > 01	0	-	27. Manner of Death	28a. Date of Inju	игу	28b. Time of		njury at Nork?		d. Describe h			,,	
Attending r death.	un fun	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	iy rear;	Injury		Yes 2 1	OV					
r Atte	by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of in	jury - At hor	me, farm, str	eet, factory, offi	CB	28	f. Location (S City or Tow			ral Route Number,	
itaio raiDi	ned in													
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica	completely filled in by the funeral	Medical	(Check only 2 Medical Ex	Physicien: To the best eminer: On the basis o	of examinati	wledge, death ion and/or inv	occurred at the vestigation, in n	e time, date and ny opinion, deat	d place, an th occurred	d due to the o at the time, o	ause(s) a date and	and manner as place, and due	stated. to the cause(s)	
of the lithing of the	eldmo	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. Lic	ense number		2	29d. Date	signed (Month	, Day, Year)	
181	ಕ) 1. h		/		Do	05325	3		3	- 31 -0	5	
			30. Name and address of person wh	o completed cause of	de th (Item	23a) (Type.								
			Timothy Snieze		_	edava		50,	te :	5 Pr	est	an, MD	2165	5
	Sta	te ar	31. Date filed (Month, Day, Year)	2005 32. Registr	rar's Signat	ure								

		ŀ	For L_ State	State of Maryla	nd / Dep		lealth and N	-	/giene	0.05	12852
			Ragistrar 1. Decedent's Name (First, Middle, La	ast)		Timoato or	Death	2. Date of D	Reg. No."		3. Time of Death
	Physicia	an						Month	Day	Year	
	/Medid Examin	-	Joseph Drey 4a. Facility Name (If not institution, gi	haupt ve street and number)		4b. City, Town, o	r Location of Death	Apri		2005 ounty of Death	3:22P [™]
			Frederick Mem	orial Hospi	tal	Frede	rick		Fr	ederio	k
	Funeral		Social Security Number 6.	Sex 7. Age (In yr.	s. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth Pay Year)	9. Birthp	place (State or Foreign
	Director		133-07-0927 Usual Residence of Decedent	1录M 2□F 87	Yrs.			Aug.	31 ^{, Year)} 19	I Ne	ew York
	land ow		10a. State 10b. County	10c. C	City, Town or L	ocation				1	IOd. Inside City Limits
	Mary I sh	tor	Maryland Fred	erick		Ros	emont				1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street and Number			10f. Zip Code	750			n of What Cour	ntry?
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinatment be notified at		3504 ChickLane				.758			U.S.A.	
	tems erms	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	0- 14.	Race - Americ Black, White,	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ⊠Yes 2 □ No If Yes, Give U W Year or Date W W	II	1 ☐ Yes 2 🔀 No	Specify:		SI	pecity: Whi	ite
Maryland 21215-0036	tural E		15. Decedent's B	Education	16a. Dece	edent's Usual Occup	ation		16b. Kind	of Business/In	dustry
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멀	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	ne (First, Middle	e, Maiden Su	ımame)	
yla	should tind Ment a marked umatic e	70	Theodore Drev				Susan N				
lar	2 short and is m		19a. Informant's Name/Relationship			ing Address (Street			-		
	1 and Health em 27 ther to		Elizabeth S. Drey			Chick La		nont, M		$\frac{d}{d} \frac{21/5}{21}$	
or.	Pages 1 nent of H ont: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3	☐Removal from State	cemetery, cre	osition (Name of amatory or other pla	ce)			•	
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice			rg Cremat		L 12, 2	C CO	IIII UNSDU	irg, MD
Ba	permit. Departr Importe any inje		IT IN A	MC	00021	Koonov	and Racfo	ord Fun	eral H	ome	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused the de	eath. Do not er	nter the mode Fras	t Church	Street	arres red	erick.	VI. 102
			shock, or heart failure. List onf Immediate Cause (Final								Interval Between Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonsi	equanna off):						
V	ate be executed nysician and he burial-transit	Examiner	that initiated events	c							
60,	e exe ian au urial-t		resulting in death) Last	Due to (or as a cons	equence of):						
2	ate br hysic the br	llcal		d		···					
₹ 89 7 89	entific fing p	Med	IF FEMALE:	23c. If yes, outcome of preg							
Вох	The law requires that the death certiticate ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fe	etal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		230	d. Date of delive Month	ery Day Year
o.	at the de by the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	r death 5						
P.O.	that the second		Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying cause gr	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
50	w requires that been signed b should be deta	d by	hype=tensim	hyperlin	mabis	ia tais	Your	1 🗆]Yes 2□I	No 3 ☐ Prob	pably 4 Wunknown
OS	w req	lete	410 2	and loca-	1	can	cet	24a. Wa		24b. Were auto	opsy findings available
Re	The lav	Completed	0, 0,	1	3 (00)			per	opsy formed?	death?	mpletion of cause of
ta	icien: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea				
Division of Vital Records,	S S	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{A} \)	Hospital: 1 ☐ Inpatient 2	TER/Outpatie	ent 3 DOA Ott	ner: 4 Nursing H	ome 5□Res	sidence 6	Other (Specif	(y)
0	ng Ph Iter th neral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	ry at rk?	28d. Describe	how injury o	ccurred	
Sio	eath. or: A	catle	2 Accident investigate	be			Yes 2 □ No		10		
≅	or Attending ifter death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not determine			treet, factory, office			(Street and fown, State)	lumber or Rura	al Route Number,
	urs al					4			(-)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		Physician: To the best of my kaminer: On the basis of examinar and manner stated.							
	within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. Licen:	se number		29d. Date s	igned (Month,	Day, Year)
	⊢ ≯ ⊢ ō		▶ (Spoler &	Seldulos		OGNI	56890		4/10	105	
	1		30. Name and address of person wh	o completed cause of death (II	tem 23a) (Type	Print)			11.	1	
	5		(ardline Ces	4	alla	trevie	Swenist	(MD)	31716		
•	Sta		31. Date filed (Mont) (PDYe1r) 5	2005 32. Sigistrar's Sig		1					
	Registr	rar		Marie	13 1	SORAN D					

			1 - For State Registrar	State of Ma	arylan		artmen rtificate					Reg. N)	285	3
	Physic	ian	1. Decedent's Name (First, Middle, Las	,	Tag						2. Date of De Month	D		ear	3. Time of Dea	ıth
	/Medi	cal	4a. Facility Name (If not institution, give	Delaney,	Jr.						March	$\overline{}$	2005		8:15A	М
	Exami	ner	Southern Marylane				Clin		Location o	f Death			c. County of			
	Funeral		5. Social Security Number 6. S		(In yrs.	last birthday)	If Under		If Under 2	24 Hrs.	8 Date of Bir		ince			
	Director			ØM 2□F	71	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da une 29	y, Year			ace (State or For try) ington,I	
	a-f show	ctor	10a. State 10b. County Maryland Prince	George	10c. City	y, Town or Lo		rest	ville	2				10	0d. Inside City Lin 1∑Yes 2 ☐	
	th with the 23e or 28	Funeral Director	10e. Street and Number 5400 Stoney Mead	low Drive			10f. Zip		0747				itizen of Wha		•	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28e-f show other traumatic event, the Midical Examination (1916) at	b	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	10	53	Was Deced f Yes, spec		spanic Orig , Mexican, Specify:	in? (Spec Puerto R	cify Yes or Notican, etc.))-	14. Race - A Black, V Specify:	White, e	itc.	
215-0	ithin 72 h ne. nen "natu Morell	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		+)		kind of wor DO NDT us	k done di e retired)	uring most		g	16b. F	(ind of Busin	ess/Ind	ustry	
12	led w lygier her th		12th			Carto	graph							Gove	rnment	
Maryland 21215-0036	ould be fill Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) James Delaney								(First, Middle, Butler	, Maider	Sumame)			
2	1 and 2 sho Health and Iem 27 Is ma		19a. Informant's Name/Relationship (7 Delores I. Delane								Route Number					
ore,			20a. Method of Disposition	Damas of the Chats	20b. PI	lace of Dispos emetery, cren				Da			ocation - City			
Ĕ	nit. Pages artment of l ortant: If its injury or o		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify							ril 5	, 2005	Ch	eltenh	am.	MD.	
Baltimore,	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licent		085		Name and				ge Fune 38 Mar restvi					
	Medical System and Make in the prize transit the prize transit the prize transit trans	ledical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last	a Due to (or as a b Due to (or as a c Due to (or as a d	consequ	ience of):	's D)err	penTu	a					Interval Between Onset and Death	
. בסג פ	ueam certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3 🗌	Ectopic pre Other (spe						23d. Date of Month		/ Day Year	
ras, r	pe ig	by	Part II. Other significant conditions co	ntributing to death but	not resu	lting in the un	derlying car	use given	in Part I.		23e. Did to	3	_1		cause of death?	
מו עפנס	ate has b	e Completed	Intra Cereby 25. Was case referred to medical	al her	nm	orhag	£			_	24a. Was a autop perfor	sy	24b. Were prior death	to comp	sy findings availal pletion of cause o	ble of
DIVISION OF VITAL RECORD	h. After this funeral di	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Accident investigation	1 ☐ Inpatient 1 ☐ Inpatient 28a. Date of Injury (Month, Day		ER/Outpatient 28b. Time of Injury		Other: c. Injury a Work?	4 🗆 Nurs	ing Home	Check only or 5 Resid d. Describe h	ence (pecify)	il.	
	5 # 15 E	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Płace of Injur building, etc.	y - At hon (Specify)	me, farm, stre	et, factory,	office		281	Location (S City or Tow			Rural F	Route Number,	
A Leginory	in 24 hours in 24	Medical	29a. Certifier (Check only one) 15 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamınatıd	rledge, death on and/or inve	occurred at estigation, in	the time	date and l	place, and occurred	d due to the c at the time, d	ause(s) late and	and manner place, and d	as stat	ed. ne cause(s)	
To T	within 2 To the complet	Σ	29b. Signature and the of certifier				29c.	License r	umber		2	9d. Dat	e signed (Mo	onth, Da	ly, Year)	
1			M. Kahu	wide MC)		1	200	52	999		3	1291	5		
(6)		30. Name and address of person who co	mpleted cause of dea	th (Item :	23a) (Type, P	rint) RRP	TT	SRO	DAD	205	- C	LINT	on	207 MD	35
	Sta Registr	••	31. Date filed (Month, Day, Year) APR 0 4 2005	. Registrar	s Signatu	A Par	W									

			1 - For State Registrar	State of Maryla			of Health and of Death		iene	12854
	Physic	ian	Decedent's Name (First, Middle, Last	•				2. Date of Dea		3. Time of Death
	/Medi	cal	ETHEL HATT		N.				26, 2005	6:50P M
	Exami	ner	4a. Fecility Name (If not institution, give SUBURBAN HOSP)			•	wn, or Location of De HESDA	ath	4c. County of Death MONTGOME	
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday)	If Under 1 Y	ear If Under 24 H	rs. 8. Date of Birth		
	Director		083 - 01 - 5037	³ M 3 √ F 8	7 Yrs.	Months D	ays Hours Mi	n. 8. Date of Birth (<i>Month, Day,</i> NOV • 19	, 1917 NE	place (State or Foreign ntry) W YORK
	and *		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	cation				10.11-11-03-11-1
	Manyli f sho	ō	MARYLAND MONTGOM				C			10d. Inside City Limits 1 X Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	SK1	GAIII	10f. Zip Co		1	Og. Citizen of What Cou	
	th with		17724 STONERIDGE	E DRIVE		2	0878	Į	JNITED STAT	ES OF AMERI
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent	of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Ameri Black, White,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	☐Yes 2🏻		, 5,5,7	Specify: WH	
9	d within 72 hours after death with the Maryland Jone. I than "natural", or items 23a or 28a-f show The Medical Exerting frust be publied at	ed k	15. Decedent's Edu		16a, Deced	ent's Usual O	ccunation		16b. Kind of Business/Ir	
215	within 73 ene. then "m	piet	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give life. L	kind of work d OO NOT use re	one during most of wastired)	orking	TOD. TAING OF DUSINESSYN	idustry
2	a filed wit Il Hygiene other the	Completed	12		HOME	MAKER			OWN HOME	
and	be filed stal Hyg ad othe event,	Be	17. Father's Name (First, Middle, Last) ABRAHAM SHINDLE	7D				ame (First, Middle, A		
<u> </u>	should be ind Mental markad (umatic ev	င	ADRAHAM SHINDLE 19a. Informant's Name/Relationship (Ty		10h 14:15-			Y FEIRSTEI		
Maryland 21215-0036	Ith an 27 is r traus		MARVIN DORFMAN -		1772	4 STON	ERIDGE DR	Rumai Houte Number, LVE,GAITH	City or Town, State, Zip HERSBURG, MI	O 20878
Baltimore,	1 ar		20a. Method of Disposition		Place of Dispos	sition (Name o			20c. Location - City or To	
<u>m</u>	Pages nent of Pages ant: If its	1	1 □ Purial 2 □ Cremation 3 □ Purial 2 □ Cremation 3 □ Other (Specify)	lemoval from State KIN	•	=	IAL GARDEN		ALLS CHURCE	H. VA
Salt	permit. Departr Imports any inju		21. Signature Truneral Service Liccos	96	22 F.D	Name and A	ddress of Facility ACFT FILMER		CION, INC.	
_	66202		(Cory)	· · · · · · · · · · · · · · · · · · ·		91 ROC	KVILLE PIR	F ROCKUT	TIE MD 209	852
Ш			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.				ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ACUTE MYOCA		NFARCT	ION			Onset and Death
	Examiner			Due to (or as a conse- CONGESTIVE		YOPATH	Y			
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ai E	rossing in dodiny Edge	Due to (or as a consec	quence of):					
687	ficate p phys s the	edicai		J						
Box	leath certific attending p I for use as I	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn		•			23d. Date of delive	NDV
m m	death ne atte	sicia	in the past 12 ponths? 1 ☐ Yes 2 ②No	1 Live birth 2 Fett		Ectopic pregna Other <i>(specif</i> y			Month	Day Year
P.O.	that the de led by the a detached f	Phys	9 Unknown	9 Unknown						
Š,	uires tha signed d be del	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause	given in Part I.		acco use contribute to the	
Records,	w requir been si should	Completed						1 🗆 Ye:		ably 4 Unknown
Re	The lav	mpi						24a. Was an autopsy perform	prior to cor	psy findings available apletion of cause of
		e Co	25. Was case referred to medical		-		00 Plane of De	1□ Yes 2	No 1□Yes	X □ No
=	ysician: is certific director,	0	examiner?	ospital: 112 Inpatient 2	ER/Outpatient	3□ DOA	04	ath (Check only one	nce 6 □Other (Specify	()
0	ding Ph h.' After th funeral	T :uc	27. Manner of Death 1 ♣ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work?	28d. Describe how		7
Sio	Attendia death.' ctor: A y the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ No			
Division of	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre fy)	et, factory, offi	ce	28f. Location (Stre City or Town,	eet and Number or Rura. State)	Route Number,
	spital ours ours ours ours (29a. Certifier 1X Certifying Phys	ician: To the best of my kno	owledge death	occurred at the	e time, data and place	and due to the ear	(a) (a) and and a	
	To the Hospital or Attending Physician: initing 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ation and/or inve	estigation, in m	ny opinion, death occ	urred at the time, dat	te and place, and due to	the cause(s)
	To the To the Comp	Ĕ	29b. Signature and title of certifier	2 000 12 1	M.D.		ense number	29	d. Date signed (Month, L	Day, Year)
			Meparat	Jo war	1/10,	D-	-27660	M	ARCH 27, 20	05
	3		30. Name and address of person who co			,				
	C+o	.0	ALPANA GOSWAMI	M.D. 111		VILLE I	PIKE, SUIT	E G-100,	ROCKVILLE,	MD 20852
	Sta Registr		MAR 3'1 2	UU5 Sereva	K A	sell!				

TITEL DOKLMAN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** $2^{60}05$ 26° 12 Noon M Ethel T. Denis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 0ct. 22, 1917 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2 🙀 F New York 87 579-09-2967 **Director** Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Madical Examinar must be notified at ty⊡Yes 2□No Directo Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Š Specify: White 3 XWidowed 4 ☐ Divorced Completed . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 Is marked other than "n any injury or other traumatic event. College (1-4or 5+) 2 Years Elementary/Secondary (0-12) Typist U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Tanenbaum Tessie Silverman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce G. Sands - Daughter 10 Starlight Court, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State King David Mem. Gdns 3/31/2005 Falls Church, Virginia * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Edward Sagel Funeral Direction, Inc. Donald. 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Le. Approximate Interval Between Onset and Death Immediate Cause (Final Prrysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-transit Due to (or as a consequence of): attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 🗆 Yes 21210 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? Be 26, Plage of Death (Check only one) Other: 42 1 Tes 2 No Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Jursing Home 5 Residence 6 Other (Specify) of funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. In 28d. Describe how injury occurred After t Certification: Division To the Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 🗌 Yes 2 No Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year, 29b. Signature title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Priot) 3 SH ٤ State Registrar

			1 - For State Registrar	State of M	aryland / Dep	artment of I		Mental Hy	200	15 10056
			Decedent's Name (First, Middle, La	st)		ramouto or	Douin	2. Date of De	Reg. No U	3. Time of Death
	Physic		Christopher	Lynn	Dur	han		Month	_	Year
	/Medi Exami		4a. Facility Name (If not institution, giv			,	or Location of Dea	April	4c. County of	03:40 P.M
1			11 W. Center Str	eet		0akland				tt County
	Funeral		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr			Birthplace (State or Foreign Country)
	Director		213-96-6281	M 2□F	36 Yrs.	Months Days	Hours Min	Month, Da		Maryland
	pur *		Usual Residence of Decedent 10a. State 10b, County		40.0.5				1,1707	maryrand
	sho	7			10c. City, Town or Lo	cation				10d. Inside City Limits
	r 28e-f show	Director	MD Garr	rett		0ak]	and			1 GtyYes 2 □ No
	death with the Maryland ms 23e or 28e-f show must be redified at	ā	100. Street and Number 11 W. Center Str			10f. Zip Code	0.1 = = 0		10g. Citizen of Wi	
	eath w	Funeral	11 W. Cellter Str	12. Was Decedent	Everin II S		21550			SA
40	ter dea	in in	1 X Never Married 2 Married	Armed Forces?		Was Decedent of I If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puei	Specify Yes or No to Rican, etc.)	- 14. Race Black	 American Indian, White, etc.
036	hours after turel', or Ita	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠ No	Specify:		Specify:	White
Õ	should be tiled within 72 hours nd Mental Hygiene. marked othar than "naturel", imetic evant, the Medical Eva	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occur	pation		16b. Kind of Bus	iness/Industry
21	thin 7	pie	(Specify only highest gra	College (1-4or !	life	kind of work done DO NOT use retire	during most of wo d)	rking		
21	ad wi	Completed	, , , , , , , , , , , , , , , , , , , ,	4	, I	Complia	nce Offi	cer	Ran	king
pu	al Hy	Be (17. Father's Name (First, Middle, Last)			•	18. Mother's Na	me (First, Middle,	Maiden Sumame,	
<u>yla</u>	Ment Ment arke etic	2	Charles E	dward	Durben		Ida	Thomp	son	Moon
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with it of Health and Mental Hygiene. If itam 27 is marked othar than "naturel", or Itams 23e or or othar treumetic evant, the Medical Evant ner must be		19a. Informant's Name/Relationship (,	19b. Mailir	ng Address (Street	and Number or R		ar, City or Town, S	tate, Zip Code)
	1 and 2 sl Health and tam 27 ls r		Charles E. Durbe	n/Father	11 W	. Center	St., 0a	kland, M	d. 21550	
Baltimore,	permit. Pages 1 a Department of Hes Important: If itam any injury or otha ence.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location - C	ity or Town, State
Ë	Part Ind.		'4 ☐ Donation 5 ☐ Other (Specify	()	Garrett C	o. Mem.	Gdns 5/	5/05	0akland	, Maryland
3ali	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	Ph 1	22	. Name and Addre	ss of Facility	3	2 S. Seco	
	<u></u>		"Slokely N=	Klim		ewart Fu				Md. 21550
	Cate be executed // Medical ward in the burial-transit	ai Examiner	23a. Part1. Enter the disease, of composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any country of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Oue to (or as c.	a consequence of):	Shot		wou		Interval Batween Onset and Death
, P.O. Box 68	that the death certifi ed by the attending p detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions co	4□Pregnant at 9□ Unknown	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify) derlying cause giv		23e. Did to	23d. Date of Month	,
Records,	quires in sign uld be							1 🗆 Y	es 2 ZN o 3	☐ Probably 4 ☐Unknown
000	law requir as been s 2 should	Completed						24a. Was a	n 24h We	re autopsy findings available
Ä	The la ate ha page 3	mo						autop	sy prio	or to completion of cause of
-	(G) LT	0	25. Was case referred to medical				OF Place of Dea			Yes 2□ No
>	ysici is ce direc	OB	examiner? 1 XYes 2 □ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatient	3□ DOA Othe	er.	th (Check only or one 5 Reside		(Specify) At scene
		T:u	27. Manner of Death	28a. Date of Injur	v 28b. Time of	28c. Injury	at		ence 6XIX Other (ow injury occurred,	Specify) At Scelle
ior	Attanding I death. sctor: After	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	FOUNCE Day	Year) Funding	Worl '⊡1 M⊊	r? Yes 2. No	Decoas	ed shot	self
	l or Attanafter deatl Director: in by the	Certification;	3 Suicide 6 ☐ Could not be determined		ry - At home, farm, stre			28f. Location (S	treet and Number	or Rural Route Number,
Ö	s after s after al Dire ed in b	Cer		building, etc	LOW	2		Oalc. land		O GARRETT CO,
	a Hospital of 24 hours a service a Funeral Detection of the control of the contro		29a. Certifier 1 Certifying Phy (Check only 2 X Medical Exam	sician: To the best o	f my knowledge, death	occurred at the tim	e, date and place	and due to the c	000(a) and man-	
	To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai	one)	and manner sta	examination and/or invi	estigation, in my of	ornion, death occur	rred at the time, d	ate and place, and	due to the cause(s)
	To that within 2 To that complet		29b. Signature and title of certifier	10 /1	1	29c. License	number	2	9d. Date signed (A	Month, Day, Year)
,			TICH	V		OCME			April 3	, 2005
			30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type, F	rint) 111 D	onn Ct	+ D-11	Imarca M	201001
		2	>. (C. 1-1)	06111		111 P6	em stree	ET Balt	unore, Ma	ryland 21201
	Sta Registra	re.	31. Date filed (Month, Day, Year)	32. Registra	's Signature					

			1 - For State Registrar		artment of Health and		0000
			Decedent's Name (First, Middle, Last)		unionio oi boutii	2. Date of Death	3. Time of Death
	Physici		John H. Doud, Jr.			Month	Day Year
	/Medi Examir		4a. Fecility Name (If not institution, give street and	number)	4b. City, Town, or Location of Deal		2, 2005 7:45 A M
	- Xuiiii		Beverly Healthcare	·	Frederick		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs	8. Date of Birth	Frederick 9. Birthplace (State or Foreign
* 1	Director		233-30-8813 1 [™] 2□ F	80 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Y	
	D.		Usual Residence of Decedent			NCL. JI,	1924 Kentucky
	how show	_	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Se-f-	cto	Maryland Frederick	Fre	ederick		1X Yes 2 □ No
	ith the	Director	10e. Street and Number		10f. Zip Code	10g	Citizen of What Country?
	23a	E	2100 A. Whittier Drive		21702	Į	Jnited States
	tems ferms	Funeral	11. Marital Status 12. Was D Armed	Forces? World	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or i	by Fi	If Yes	s 2□No Give WarTT	☐ Yes 2♥ No Specify:	, 5.0.,	
21215-0036	72 hours after death with the Maryland Instural, or Items 23a or 28e-f show dical Examiner must be notified at	D D		Dates:			Specify: White
ا بَ	n 72	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	lent's Usual Occupation kind of work done during most of wo	rking 16	b. Kind of Business/Industry
12	within ene. than *	Ę		(1-40r 5+)	er Electrician		Electrical
2	filed Hygi other	e C	17. Father's Name (First, Middle, Last)	nast		me (First, Middle, Ma	
a	d be antai	00	John H. Doud, Sr.			,	iden Sumame)
2	2 should be and Mental Is marked c	ပ္	19a. Informant's Name/Relationship (Type, Print)	10h Mailin	g Address (Street and Number or Ri	y Leman	7
			Janet Blaylock / Daught		Blue Heren Drive		
a)	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.	1.5	20a. Method of Disposition	N		the same of the sa	c. Location - City or Town, State
Baltimore,	ages nt of nt of t: If it		1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal fro			/2005	
턮	it. Partme	99	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		or omacor,	L.	rederick, Maryland
Ba	Depa Impo any ic		21. Signature of Pulleral Service Electrises		Name and Address of Facility S1		
			232 Part 1 Enter the discord or complications the				derick, MD 21702
			23a. Part 1. Enter the disease or complications the shock, or heart failure. List only one cause of			or respiratory arrest	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Myoea	udia Infa	cetion.	Criser and Death
	Examiner		Due	o (or as a consequence of):	, ,		
		-	Sequentially list conditions, if any, leading to immediate Due 1	o (ur as a consequence of):			
	ted isit	Examiner	cause. Enter Underlying Cause (Disease or injury	o for sale enuacinous on).			
	and and II-trar	xan	that initiated events c.	o (or as a consequence of):			
8760,	cate be executed obysicien and the burial-transit			o (o. do a sanoquence on).			
687	phys phys the	Physician/Medical	d.				
×	The law requires that the death certifics tite has been signed by the attending ph bage 2 should be detached for use as t	/Me	IF FEMALE: 23c If yes	utcome of pregnancy			
Вох	atter for u	lan	in the past 12 months?	birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
o i	that the death cered by the attendir	ysle	1 Yes 2 No 9 Unknown 9 Unknown		Other (specify)		
۵.	that ed by deta		Part II. Other significant conditions contributing to	death but not resulting in the un	deriving cause given in Part I	23e. Did tohac	co use contribute to the cause of death?
Vital Records,	signed I	d by			denying database giran in rancin		2 No 3 Probably 4 Donknown
Ö	w requir been si should	ete					22,10 02,1002, 120,100
ĕ	has has	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
						performed	
=	sicien: certific rector,	Be	25. Was case referred to medical examiner?		Out -	th (Check only one)	
	this al di	٦.	T THE ZILAND	Inpatient 2 ER/Outpatient			e 6 Other (Specify)
L .	After funera	5	1 ☑Natural 5 ☐ Pending (Mc	e of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how i	injury occurred
S	death. ctor: A y the fu	ical	2 Accident investigation 3 Suicide 6 Could not be	an of laine. At home form stre	M 1 Yes 2 No	006 1 (04	
Division of	offer death	Certification;	4 Homicide determined 286. Fla	ce of Injury - At home, farm, stre ding, etc. <i>(Specify)</i>	et, factory, office	City or Town, S	t and Number or Rural Route Number, tate)
	spitel or ours eft nerel Di filled in		29a, Certifier 1 Certifying Physician: Tot	20 hoot of my knowledge, dooth		11	
-	24 h	edical	Check only 2 Medical Examiner: On the	basis of examination and/or inviner stated.	occurred at the time, date and place estigation, in my opinion, death occur	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
-	lo the hospitel of Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the funerel.	Mec	29b. Signature and title of certifier	ringi Stateu.	29c. License number	294	Date signed (Month, Day, Year)
1	- s - ō			000	20001		
	VX,		30 Name and address of paragraphs and address of paragraphs	Iso of death (term 22-) The	N 28371		1-4-05
	12		30. Name and address of/person who completed ca		House Are. F	rederich	MO 21201
	Stat	e		Re strar's Signature	4	www.cm	110 21701
	Registra	_	MIN 0 4 2003	Februar St. A.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 March 31, **Physician** George Cleland DeNeale 1:00 pmm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Frederick Frederick tf Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Mar 19, 1 Birthplace (State or Foreign Country) **Funeral** Days 1XX M 2□ F 226-42-7614 83 Director Vrs Washington DC Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at Maryland Frederick Frederick Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after a and Mental Hygiane. Is marked other than "natural", or Ital 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Newspaper writer Syndicate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Cleland DeNeale Sr Eleanor Corcoran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is: Linda Harris / Friend 5577 Rivendell Place, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Cemetery Apr 4, 2005 Frederick, Maryland 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Important: If any injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| Improduct Course (Fig.) | Proceedings and process of Facility | Keeney & Basford P.A. Funeral Home | 106 East Church Street, Frederick, Maryland | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 21701 | 217 22. Name and Address of Facility proximate Interval Between Onset and Death Immediate Cause (Final ROGRESSI ve Dene Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). ed by the attending physician and detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 1 Tyes 2 No Be 25. Was case referred to medical 26. Place of Death Check onlone examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: the HospitsI or Attending I hin 24 hours after death. the Funerel Director: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of ¢ertifier, 29c. License number 29d. Date signed (Month, Day, Year) D58391 March 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sajjed Aziz, M.D., 801 Tollhouse Avenue, C-3, Frederick, Maryland 21701-4555

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month Day)

32. R

4 2005

sistrar's Signature

1-	For Stete Registrar	State o
1. D	ecedent's Name (First, Middle, Last,	

of Maryland / Department of Health and Mental Hygiene

ar	Certificate of Death	Reg	g. No.)	10000
's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
les Emanuel Epps, Jr.		March 3		9:37 A. M
lame (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Manorwood Drive	Hvattsville		Prince Geor	rgo ' e

Examiner **Funeral**

Director

ral', or items 23e or 28a-f show Evaruper is ust be notified at

Physician /Medical **Examiner**

> attending physician and for use as the burial-trar signed by t After this

Certification:

Medical

Physician Char /Medical 4a. Facility N 3531 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1**⊠**M 2□ F 58 Yrs. 11/16/46 Wash.,D.C. 578-60-6968 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Md. P.G. <u>Hyattsville</u> Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3531 Manorwood Drive 20782 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 28 Married 1 ☐ Yes 2 No Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Subway Station Operator <u> Metro</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Epps, Sr. Thresa E. Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Wanda J. Epps/Wife 3531 Manorwood Dr. Hyattsville, Md. 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) Harmony Mem. Park 4/5/05 Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co. Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately and the such as a cardiac or respiratory arrest, Approximately arrest and the such as a cardiac or respiratory arrest and the such as a cardiac or respiratory arrest and the such as a cardiac or respiratory arrest arrest and the such as a cardiac or respiratory arrest and the such as a cardiac or respiratory arrest and the such as a cardiac or respiratory arrest arres Ruy Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Cancer 24 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): by Physician/Medical Be Completed ျှ

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	23d. Date of delivery Month Day Year					
Part II. Other significent conditions	contributing to death but not re	sulting in the unde	rlying cause given in Part		y prior to completion of cause of death?		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No				e of Death (Check only one	ath <i>(Check only one)</i> Home 5 ffResidence 6 □Other <i>(Specify)</i>		
27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2	28d. Describe ho	28d. Describe how injury occurred		
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Str City or Town	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	hysicien: To the best of my kn miner: On the basis of examin and manner stated.				ause(s) and manner as stated. ate and place, and due to the cause(s)		
29b. Signature and little of certifier		29c. License number		29d. Date signed (Month, Day, Year)			

D0041119

State Registrar

Daya S. Sharma, M.D. 31. Date filed (Month, Day, Year, APR 0 4 2005

eest

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

9801 Georgia Ave. # 1-18, Silver Spring, Md.

20910

April 1,2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #26, 4/5/05, cwc, Kent Co State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ROBERT Α. **EDWARDS** APRIL 2005 1:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth July 11 1921 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Min. 83 Kentucky Director 577-12-7246 Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location show 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No Directo MD Queen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1421 Millington Rd. 21668 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1942 If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Mudical Examina. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: -1945Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Mechanic Heating - Plumbing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Edwards Viola Combs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21668 Juanita Matthews (friend) 1421 Millington Rd. Sudlersville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 Donation 5 Dother (Specify) Galena Cemetery 4/7/05 Galena, MD. 21. Signatur of Fuheral Service Licers Calena Funeral Home of Stephen L. Schaech MO0510 118 West Cross St. Galena, MD. 21635 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eu Comia Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 2 anner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 2 Accident

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0051786 30. Name and ad ress of perso who completed ca of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Andrew S. Ferguson, $M \cdot D$. 120 Speer Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year)

Registrar

filled in by

Medical

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of pertifie

29a. Certifier



State of Maryland / Department of Health and Mental Hygiene 1 5 12861 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** Betty J. Gadow March 29, 2030 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4010 Houston Branch Road Federalsburg Caroline If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 25, 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 1 F 78 212-22-9280 Yrs Director Kentucky Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City. Town or Location 10a State 10d. Inside City Limits 28a-f show itam 27 is markad othar than "natural", or items 23a or 28a-f shov other traumatic evant. The Modical Examinar must be notified at Caroline Federalsburg MD 1 Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 4010 Houston Branch Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) USDA Grader Perdue Farms Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If itam 27 Is markad of Homer McCov Linda McCoy McCoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2163219a. Informant's Name/Relationship (Type, Print) Sue Tull/Daughter 4010 Houston Branch Rd., Federalsburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) = 5 permit. Page Department of Important: If any injury or once. Junior Order Cemetery 04/03/05 Preston, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 spen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each liny. Immediate Cause (Final Fnysician ung Cancinom disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D known page 2 should 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 2 No 1 Tes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division 5 Pending after death. 1 □ Yes 2 □ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours a To tha Funaral C ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and 4/1/05 address of person who completed cause of death (Item 23a) (Type, Print) Washington St Baston mo 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 = For State Registrar	State of Man		artment of H			Reg. Nø.	05	1281	62
Physici /Medic		Decedent's Name (First, Middle, Last, Decedent's Name (First, Middle, Last,) ONALD WILLI	AM, FALCO	NER		2. Date of Dea Month April	2 Day	20 ⁷ 05	3. Time of 0	A M
Examin	er	4a. Fecility Name (If not institution, give Buckingham's Choic		it Comm.	4b. City, Town, or Adams to	wn		Fre	nty of Death ederick		
Funeral Director		-31 10 0130	x 7. Age (l. x 2 □ F	n yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		1914	9. Birthp Coun Ohio	ace (State or try)	Foreign
he Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic		Oc. City, Town or Lo	vn					0d. Inside City 1 ☐ Yes	
h with t	al Dir	10e. Street and Number 3200 Baker Circle	Apt. I-233		10f. Zip Code 21710				of What Coun .S.A.	try?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If time 77 is marked other than "neturel", or items 23e or 28a-f show any injury or other treumatic event, Ite Madical Examitizations to other treumatic event, Ite Madical Examitizations to other treumatic event, Ite Madical Examitizations.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Eve Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: W		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? n, Mexican, Pue Specity:	(Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White, on Cify: Whi	etc.	
within 72 hours af	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of w)	rorking		f Business/Inc	lustry	
a filad wi Il Hygian other th	Be Co	17. Father's Name (First, Middle, Last)	4	мес	hanic Eng		ame (First, Middle,		eral Go name)	vernme	nt_
nould be filled Mental Hy narked oth	ToE	William A., Falcone 19a. Informant's Name/Relationship (T)		10b Maili	Address (Street a		. Smith	or City or To	um Stata Zin	Codal	
ind 2 st atth and 27 is n	19 3	Mary Rush (Niece)	/pe, Print)		ng Address <i>(Street a</i> Mill Cross						23454
Definition of the Department of He Department of He mportent: If item any injury or other once.		20a. Method of Disposition 1	Removal from State	20b. Place of Dispo cemetery, crei Yellow Cr	natory or other place	. 1	Date 6/05		on - City or To		
law requires that the death certificate be executed Separation and continued by the attending physician and continued be detached for use as the burial-transit Should be detached for use as the burial-transit	Physician/Medical Examiner	in the past 12 months?	Due to (or as a complete birth polymer) a. Pes piral Due to (or as a complete birth polymer) Due to (or as a complete birth polymer) 23c. If yes, outcome of polymer) Unknown	don Faul onsequence of): onsequence of): onsequence of): onsequence of): organicy pregnancy	BLANT E. 1 201 NORTH er the mode of dying	MARKET	ST., FRE	DERICK rest,	Date of delive	1701 Approximate Interval Betwonset and D	/een
uires that the	by	9 □ Unknown Part II. Other significant conditions co	ntributing to death but n	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to		ontribute to th	e cause of de	
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Phy I his	Certification; To Be	27. Manner of Death 12. Matural 2 Accident investigation 3 Suicide 6 Could not be	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day You		28c. Injury Work M 1 \(\)	er: 4 Nursing	eath (Check only o	ence 6 🗀	curred		ner
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	edical Certif	4 Homicide determined 29a. Certifier (Check only one) 2 Medical Examination	building, etc. (cascing and manner stated	Specify) ny knowledge, deati	n occurred at the tim	ne, date and pla pinion, death oc	City or Tow	m, State) cause(s) and	manner as sta	ated.	
To the within 2 To the comple	Med				29c. License	number	:	29d. Date sig	ined (Month, L	Day, Year)	
X		1 War	- MP		Dog	5870	.2	04.	-04-	5	
6		30. Name and address of person who c	ompleted cause of deat	3000 -D V	Print) ta	Myers	Me MD	31713			
Sta Registr		31. Date filed (Month, Day, Year) APR 0 5	ompleted cause of deat vien W 0 2005 32. Red strar's	Signature	Soft						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma		artment of F			iene eg. No. 2005	12000
	Physici	an	Decedent's Name (First, Middle, Last)		1			2. Date of Deat	th	3. Time of Death
	/Medi	cal	Helen G. Fishmar			# 03 T		March 25		7:40 P. M
	Examir	ner	4a. Facility Name (If not institution, give : Suburban Hospital	street and number)		4b. City, Town, or Bethesd		ith	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days			Montgome 9. Birth	TY place (State or Foreign intry)
	Director		213-40-4033	M 2□F	98 Yrs.	Month's Days	Hours Mil		1907 Del	
	show	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many e-f sh iffed	tor	Maryland Montgome	ry	Silver Sp	oring				1 X Yes 2 □ No
	or 28	Direc	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	intry?
	s 23a	rai	9520 Biltmore Driv			20901			U. S. A.	
(0	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-1 show event, the Medical Eracidise from a feet rediffied at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ANo				Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White	, etc.
21215-0036	ral', o	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖺 No	Specify:		Specify: Wh	ite
5-6	"natu	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of w	orking	16b. Kind of Business/Ir	ndustry
12	within iene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)) 1	emaker	")		Own Home	
	al Hyg	BeC	17. Father's Name (First, Middle, Last)		1			ame (First, Middle, M		
yla	12 should be filed within h and Mental Hygiene. 7 is marked other than "treumetic event, the Me.	10	Jacob Goodlevege					Bluesteir		<u> </u>
Maryland	s 1 and 2 should I Health and Men Item 27 is marke other treumetic		19a. Informant's Name/Relationship (Ty, Richard M. Fishman			-			City or Town, State, Zi	,
d)	s 1 and I Health Item 27 other tr		20a. Method of Disposition		20b. Place of Dispo cemetery, cree				20c. Location - City or T	
E O	Page nat: If		1 X Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State	Judean Me		1	9/2005	Olney, Mary	land
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		21. Signature of Funeral Service License		É	Name and Address Iward Sag	s of Facility el Fune:	ral Direct	tion, Inc.	
	Anysician /Medical Examiner	er	23a. Pant1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Pneum Due to (or as a Urose	ne death. Do not ent Onia consequence of):	er the mode of dyin	g, such as cardia	ac or respiratory arre	ille, Maryl	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cates (Lieute of Injury) that initiated events resulting in death) Last	Due to (or as a	consequence of):					
.O. Box (it the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
rds, P	quires tha n signed uld be det	by	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to t s 2 2 No 3 ☐ Prot	he cause of death? Dably 4 Unknown
		Completed						24a. Was ar autopsy perform 1 \(\text{Yes} \) X	y prior to co ned? death?	opsy findings available impletion of cause of
Vit.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	ospital: v	-7	• 3C DOA Othe	200	ath (Check only one		
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	Ö H H J S	Medical	one)	icien: To the best of er: On the basis of e and manner state	xamination and/or inv	occurred at the time vestigation, in my op	ne, date and place pinion, death occ	urred at the time, da	use(s) and manner as s ite and place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	mou	i MID	29c. License			d. Date signed (Month,	
ř			The state of	<i>y</i> 9	1 12 1		27660	M	larch 27, 20	005
	10		30. Name and address of person who co Alpana Goswami, M				G100. 1	Rockville	. Marvland	20852
	Sta Registi		21 Date filed (Month Day Veer)		s Signature		2200, 1		, mar j rana	20032

			1 - State Registrar	Maryland		icate of I		norman r ty	Reg. No.		
E	Physici		1. Decedent's Name (First, Middle, Last) Robert William Fra	ncisco.				2. Date of De Month March	nath C. U	Year 15	3. Time of Death .
	/Medic Examin	_	4a. Facility Name (If not institution, give street and num	`		. City, Town, or	Location of Death		4c. County		0.13 F
	Funeral		1 X 1M 2□ F	7. Age (In yrs. last		Edgev Under 1 Year onths Days	vater If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)		ace (State or Foreign
	Director		578-60-6129 Usual Residence of Decedent	57	YIS.			11–23–	1947	Mary	land
	yland		10a. State 10b. County	10c. City, T	Town or Location	on				10	d. Inside City Limits
	Ba-f s	Director	Maryland Anne Arundel	Ec	dgewate	er					1 ☐ Yes 2 X No
	with the	Dire	10e. Street and Number		1	Of. Zip Code	_		10g. Citizen of		
	ns 23	Funeral	4087 Shoreham Beach Rd. 11. Marital Status 12. Was Dece	dent Ever in U.S.	13. Was	21037 Decedent of H		ecify Yes or No)- 14. Rac	US.	
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or flems 23a or 28a-f show dother than "natural", or flemr must be notified at event, the Medical Exacting must be notified at	by	Armed For	rces? 2	0 If Ye	s, specify Cuba Yes 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Bla Specif	ck, White, e	
Maryland 21215-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent	s Usual Occup	ation during most of work	ring	16b. Kind of B	usiness/Ind	ustry
21	ithin 7 ne. nen "r	Completed	Elementary/Secondary (0-12) College (1-	-4or 5+)	life. DO I	VOT use retired	i)	ung			
2	iled w Hygier ther th		12th 17. Father's Name (First, Middle, Last)		Mechan	nic	18. Mother's Nam	e /First Middle	Sheet		<u> </u>
au	~ - 0 %	o Be	Robert W. Francisco	. Sr.					rine Jo	-	
ary	2 should be filed withir and Mental Hygiene. ia marked other than aumatic event, the M	۲	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing A	ddress (Street	and Number or Rui			-	Code)
	and 2 ealth a n 27 i		Dawn M. Louck/ Daughter				Edgewate				
timore,	ges 1 of He If iter or oth		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from S	PIGIO		n (Name of ry or other plac	l l	Date	20c. Location	City or To	wn, State
Ħ H	rtmen rtant: njury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee	/ CIM		s Cemet			Crowns		
Bal	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 Is marked any injury or other traumatic as once.		1 WWI Mulu		297	73 Solo	ss of Facility Geo NONS ISL	orge P.	Kalas F Edgewat	unera er, M	1 Home D 21037
	Physician /Medical Examiner	ner	Sequentially list conditions.	ach line.	DIAC nce of): KE		UFARCT	20		TWE.	Approximate Interval Between Onset and Death
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Ä		Com	DYSLIPIDEMIA					autor perfo	rmed? 2 X No	death?	pletion of cause of
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** orne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death County of Death Examiner NICOM HOSDICE O castal Jal 15bur 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1□M 2√2 F 1941 Maryland **Director** <u>214 42 8639</u> Usual Residence of Decedent death with the Maryland Show 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Items 23a or 28a-f shov It e Medical Evertinet must be rediffed at 1 Yes 2 No Directo Maryland Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Riverside Drive 21801 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72? Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nat, any injury or other treumatic event, it a Mudical any injury or other treumatic event, it a Mudical one. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Advertising Agency Owner Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul J. Gladding Ethel Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raye Vallion Gillette 100 Sout Washington St. Snow Hill, MD 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 4/5/05 Frankford, DE 21. Signature of Fund al Service Licensee 22. Name and Address of Facility 108 William St. The Burbage Funeral Home Berlin, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21811 Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţoţ in the past 12 months? Month Day Year 5 Other (specify) be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy certificate 1 Yes Hospitel or Attending Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Yes 1 patient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the F Signature 29c. License numbe 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL alfil 31. Date filed (Month, Day, Year) State APR 0 5 2005 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lionel GREENBAUM March 30, 2005 2:06 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Casey House Montgomery Hospice Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 22, 1 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) .Sex X⊓M 2□F Days Hours 075-12-6060 83 1921 England Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Montgomery Marvland Silver Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15107 Interlachen Drive #624 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) MYes 2 No fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🕽 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Toy Store 0wner 12 18. Mother's Name (First, Middle, Maiden Sumame)
Katherine Applebaum 17. Father's Name (First, Middle, Last) Abram Greenbaum 20906 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15107 Interlachen Drive #624, Silver Spring, MD Leonore Greenbaum, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Judean Memorial Gardens 04/01/05 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Olney, MD 21. Si nature of Funera Service Densee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part I Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20012 Approximate Interval Between Onset and Death WEEK Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): End Stage Cardiomyopathy Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1X Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed

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To the Hospitel or Attending Physician:

Physician

/Medical

Examiner

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Funeral

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23s or 28a-f show many jury or other treumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

nerel Director: After th

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Certification;

cal

Division of Vital Records, P.O. Box 68760,

ician/Medical IF FEMALE Physi 9 Unknown þ Completed

autopsy 2 XNo 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 ER/Outpatient 3 DOA 1 Tes 2 X No 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? House 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

D 09470

6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

March 31, 2005

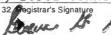
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certified 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier 29c. License number

MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10901 Connecticut Ave., Kensington, MD Eugene P. Libre, M.D.,

State Registrar

31. Date filed (Month, Day, Year) 2005



Registrar DHMH 17 Rev 1/2001

State

Paul Donaher,

31. Date filed (Month, Day, Year)

 $M \cdot D$.

2005

32. Pagistrar's Signature

119 C. North Main St. Galena,

MD.

		•	1 = For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F			iene _{eg. No.} 2005	12868
	Dhuoisi	0.0	Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	Day Year	3. Time of Death
	Physici /Medio	cal	GOLDIE		LIENE	GRC	SS or Location of Dea	April	7, 2005 4c. County of Death	7:15 A ^M
	Examir	ier	4a. Facility Name (If not institution, given Madonna Heal		,		rettsv			ford
	Funeral		5. Social Security Number 6.5	Sex 7. A	ge (In yrs. last birthday		If Under 24 Hrs	8. Date of Birth		place (State or Foreign intry)
	Director		212-22-0400	1□M 2 X)F	84 Yrs.	Michael Gays	Trouto Italia	9/15/		laryland
	land.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary F sh	ţō	MD. Har	ford		Ja	arretts	ville		1 ☐ Yes 2 MNo
	or 28s	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	intry?
	ath wi		3911 Madonna	1	5 110 140	144 - 5 4 41	21084		United 14. Race - Amer	
36	72 hours after death with the Maryland' natural', or itams 23a or 28a-f show dissal Examinar must be multiped at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	fispanic Origin? () an, Mexican, Puel Specify:	to Rican, etc.)	Black, White	
21215-0036	n 72 hours natural', polical Exe		15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	pation	advin a	16b. Kind of Business/	
215	E - 3	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4o	life.	e kind of work done DO NOT use retire	d)	orking		
21	T1 C2		17. Father's Name (First, Middle, Lasi	3		Hous	Sewife	me (First, Middle, I	HON Maiden Sumame)	ie
Maryland	be data	Be	Upton	Freder	ick	Almony	Ber			ehardt
ary	2 should and Men is marks	은	19a. Informant's Name/Relationship						City or Town, State, Z	
	s 1 and 2 should f Health and Men Itam 27 is marks other traumatic		L. Kenneth Gro	oss/Husb		l Madonr	na Rd.			Maryland
ore	0 0 -		20a. Method of Disposition 1 XBurial 2 Cremation 3 [Removal from Stat	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla			20c. Location - City or 1	
Baltimore,	Department of mportant: If It my injury or o		'4 ☐ Donation 5 ☐ Other (Speci 21. Signification of Funeral Service Lice		+	Cemeter 22. Name and Addre			Madonna,	
Ba	permit. Departr Imports any inj		21. Significate di Muneral, Service Lice	Jan H	the state of				ville, Ma eral Home	
	N Sale		23a. Part1. Enter the disease, or conshock, or heart failure. List only	aplications that caus	ed the death. Do not en					Approximate Interval Between
	Physician	ļ, ļ	Immediate Cause (Final disease or condition	- One cause on each	DIABET	FS M	TELLIT	us		Onset and Death
1 1	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	1/ 00	- · · ·	0.0		
	LAUMMICI	5	Sequentially list conditions,	b. Due to (or a	CROWA:			Disc		
$\sqrt{}$	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	A	17HEIN	nens	DEM	DONTIK	7	
oʻ	sician and burial-transit		resulting in death) Last	Due to (or a	s a consequence of):					
8760	ate hy	lical	•	d						
9 X	certificate be executed nding physician and use as the burial-transit	Physician/Med	IF FEMALE:	23c, If yes, outcom	ne of pregnancy				23d. Date of deli	/erv
Вох	atter for u	clan	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\sum \text{Vo}\)	4☐Pregnant	at time of death 5	□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
P.O.	t the by th tache	hys	9 Unknown	9□ Unknown				- 3		
	faw requires tha as been signed 2 should be de	ρ	Part II. Dther significant conditions	contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to es 2 Pro 3 □ Pro	the cause of death?
Vital Records,	The law re ete has be page 2 sho	Completed						24a. Was a autops perform	sy prior to c	opsy findings available ompletion of cause of
'ita	sician: certifice rector, p	BeC	25. Was case referred to medical examiner?					eath (Check only on		र स्राप्त
of V	Physician: this certific ral director.	은	1 ☐ Yes 2 No	Hospital: 1 Inpa		SIL 3 DOA	-	Home 5 Reside	ence 6 Other (Spec	かしいいいい
ou o		tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L		Wo	rk?]Yes 2□No	280. Describe in	ow inquiry occurred	
Division	f or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	28e. Place of	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	Hospite 4 hours Funerel	edical C	29a. Certifier 1 Certifying P	hysician: To the be- iminer: On the basis and manner	of examination and/or	ath occurred at the ti nvestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title	>		29c. Licen:	se number	1/ 2	9d. Date signed (Month	, Day, Year)
)	C6 III		PRJ/H.	W FU	15),	1).	3684	6 F	PRIL O	1,2005
	- 17		30 Name and address of person who	co pleted cause o	death (Item 23a) (Type	17 .11	RAVEN	SIVO Sui	TO 208A BA	Timun = m)
	St	ato	31. Date filed (Month, Day, Year)	32. Ragin	strar's Signature	0 20017	11001V K		000-11 -511	21235
	Regist			2005	me K	books				

WILLIAM GIDDINS 05-02477 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/Medic	ın al	Decedent's Name (First, Middle, WILLIAM THO	MAS GIDDI	NS , J	R.	I n. e.	Tour	Lasti	d Death	2. Date of De. Month APRIL	Day 9	, 200		3. Time of Dea
Examin		4a. Facility Name (If not institution, PENINSULA REGION.			R	1 .	Town, or ALISE	Location of	of Death			COMIC		
Funeral Director		5. Social Security Number 219-78-2942		Age (In yrs. la 41		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 11-8-19	th 19. Year) 1963		Count	ace (State or Fo try) "LAND
and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	ocation							10	0d. Inside City L
the Marylar 28a-f show	to	DELAWARE SUSS	EX	SE	LBYVI	LLE								1 X]Yes 2[
or 28	Funeral Director	10e. Street and Number				10f. Zip	9975				•	zen of Wh		
eath w	eral	RT • 2 BOX 95	12. Was Decede	ent Ever in U.S	S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No		14. Race	- Americ	an Indian,
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within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		NSTRU		,	KER		(CONST	RUCT	ION
0 0 -	To Be Co	17. Father's Name (First, Middle, L	ast) GIDDINS, S	SR.				CL	ARA	(First, Middle	ION			
2 shou and N is mai		19a. Informant's Name/Relationsh				_				I Route Numb				Code)
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ages of hor of h		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp		ate ZO	AR GOI	DEN A	other plac	(a)	APR.	23,200	5	BISH	OPVI	LLE, MD
permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic e ones.		21. Signature of Funeral Service L			EMETE 2	2. Name at WAT	SON	FUNER	AL H	OME, IN	NC.			
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State of Maryland / Department of Health and Mental Hygiene [] For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 2005 1602 P [™] Donald James Griffith aka: James Donald Griffith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Memorial Hospital Easton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F Months Days Hours Min Yrs. 73 Dec 29 1931 Director 214-26-5073 Maryland Usual Residence of Decedent Griffith, Donald 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 ia marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Examinar must be notified at 1 X Yes 2 □ No Maryland Caroline Ridgely Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23815 Lister Lane 21660 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give** Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Salesman 10 auto tire industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John James Griffith Minnie Elizabeth Heim Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Griffith/ wife 23815 Lister Lane Ridgely, Maryland 21660 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ridgely Cemetery 4/08/05 * 4 ☐ Donation 5 ☐ Other (Specify) Ridgely, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Corowary ars disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, is a my list immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit law requires that the death certificate be executed attending physician and for use as the buriat-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No. 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Ponknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 110 1□ Yes Hoapital or Attending Physician: 24 hours after death. funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral C Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 James 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR - 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar item #20b, per.f. home, 4/5 @srtificate of Death E.T. WCHD Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year ROBERT ADOLPH HABICHT April 1 2005 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Salisbury

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Wicomico Center Salisbury Nursing & Rehab. 8. Date of Birth (Month, Day, Year) Aug. 5, 1925 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) Months 1 M 2 F 79 Aug. Maryland 216 20 3763 Usual Residence of Decedent 10c, City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√No Maryland Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Heron Isle Court 21811 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Minnie Fischer Frederick Habicht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Heron Isle Ct. Ocean Pines. MD Ruth H. Habicht 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 4/03 /05 Frankford, DE Al Service Licensee 22. Name and Address of Facility 108 William St. The Burbage Funeral Home Berlin, MD 21811 untale Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Between Onset and Death

Physician /Medical **Examiner** or Attanding Physician: The law requires that the death certificate be executed burial-transi Division of Vital Records, P.O. Box 68760, filled in by the funeral safter death. within 24 hours a To tha Funaral C completely

Amended

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Examiner

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Director

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Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Itel

other traumatic event, the Wedical

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Department of Important; If any injury or once.

Baltimore, Maryland 21215-0036

disease or condition resulting in death)	a. aykec	cus	Disease		year	7
Saguertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	quence of):	Size lu	lary	Disease y	Par
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic			23d. Date of delivery Month Day Y	/ear
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2 4	24b. Were autopsy findings a prior to completion of ca death?	Jnknov
25. Was case referred to medical examiner?			26. Place of Di	eath (Check only one)		
1 Yes 2 No	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐	OOA Other: 4 Jursing	Home 5 Residence	6 ☐Other (Specify)	
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 Suicide 6 Could not determined		nome, farm, street, fact	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Numb ate)	ber,
29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)	
29b. Signature and title of certifer	1	2	9c. License number	29d. l	Date signed (Month, Day, Year)	

200 Civic Ave., Salisbury, Md. 21804

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

M.D.

William Robbins,

APR 05

31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 0 Year March **Physician** 9:40a^M Melvora Hasson 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Fox Chase Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🖵 F 326 16 0671 Director 07/25/14 Alabama 90 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location e filed within 72 hours after death with the Marylar al Hygiene.
I other than "natural", or Itams 23s or 28s-f ahow vent, the Marylar mater in tillied at Y☐Yes 2☐No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 416 Ingraham St.NW 20011 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2□ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avant once. Be George Hasson Carrie Tyson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Ingraham ST NW Washington, DC 20011 Willie Hasson nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Riverdale Park 4/02/05 Riverdale , Md 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee Snead funeral Home & CremationService 5732 Georgia Ave NW Washington, DC 20011 town 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure resulting in death) /Medical Due to (or as a consequence of) Examiner 2years Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed tran Due to (or as a consequence of) burial-Box 68760, Physician/Medicai as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by þe 1 Yes 2 No 3 Probably 4 ☑ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Seizure Disorder autopsy performed? certificate 3 No 1 Yes 2 No 1 Tes of Vital Gastrointestinal Bleeding 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No dire ٩ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Division or Attending 5 Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident i after death in by the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signatur D28656 March 31,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi MD, Second Ave #404 Silver Spring, Md 20910 8609 31. Date filed (Month, Day, Year) State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For Stete Registrar	State of Ma	aryland / De C	ertificate of			gierie Reg. No.	
	0.	18	Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Charles	Donald_		Hambur	g	April	10, 20	
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			917 St. Clair St. 5. Social Security Number 6. S		e (In yrs. last birthda		stown If Under 24 Hrs.	8. Date of Birt	Washin	gton Birthplace (State or Foreign
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	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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	with th		10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
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36	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Medical Examiner must be motified at	by Fun	1 ☐ Never Married 2 💢 Married	Armed Forces? 1 X Yes 2 1 If Yes, Give	1945	 Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No 		Rican, etc.)	Black, W	hite, etc.
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yla	should be nd Mental markad o umatic eva	ပ	John K. Hamburg 19a. Informant's Name/Relationship (Time Drintl	105.14	State Address (Otton		nes Doug		7 0 11
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nore	ages 1 ar nt of Hea t: If Itam / or otha		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		cemetery, c	position (Name of rematory or other pla	ice)	Date / 2005	20c. Location - City	
Baltimore,	permit. Pages 1 Department of H Important: If Its any injury or ot		'4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer			22. Name and Addr	ess of Facility Re	est Have	Smithsburg n Funeral	Chapel
	20599		> 3 which day	γ	1		•	-	-	MD 21742
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.O. Box (death cer e attendir ad for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	B Ectopic pregnanc D Other (specify)	у		23d. Date of o Month	delivery Day Year
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		į		Mulom	On the Change Control	D4166	7		April 11,	2005
	1321		30. Name and address of person who Michael McCormack	11110	Medical (Campus Dr.	, Hagerst	own, MD	21742	
* :	Sta Registra		31. Date filed (Month, Day, Year) APR 15 2	32. Jegistra	r's Signature	berte				

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Ì	Physici /Medio	al	Decedent's Name (First, Middle Clarice 4a. Facility Name (If not institution)	Hart	r)		4b. City.	Town, or	Location		Date of Dea Month	30	Year	3. Time of Death 4:10 PM
	Examin Funeral Director	er	Prince George 5. Social Security Number 231-26-0935	s Hospita	1 ge (In yrs.	last birthday)		ver1			Date of Birti	Pr	ince (Georges hplace (State or Foreign huntry) ginia
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	th with the 23a or 28 ist be not	al Dire	10e. Street and Number 13406 Messeng	er Pl.			10f. Zip	Code 2077	7 4			10g. Citiz U	zen of What Co	untry?
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturel", or Items 23a or 28e-f show marked other than "naturel", or Items 23a or 28e-f show marked other than "nature event, the Medical Extrainer is used by midlified at	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceden Armed Forces ed 1 Yes 2 If Yes, Give Year or Dates	?] No		Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		fy Yes or No- can, etc.)		14. Race - Ame Black, White Specify: B	e, etc.
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	and 2 sealth ar m 27 is			Daughter	20b. F		6 Me	sser			Uppe	r M	Town, State, 2 [arlbo] cation - City or	ro, MD
Баітітоге,	permit. Pages 1 Department of H Important: If ite any injury or ott		1 Burial 2 Cremation 4 Donation 5 Other (St	pecify)	Ca	Ivary	Cem	ther place eter d Addres	s of Facilit	4-11- Vay1o	05 N	orf	olk, v	JA
	Pnysician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. SEPS of Due to (or a Due to (or a	s a conseq AN C s a conseq	uence of):	er the mod	e of dying	g, such as				1	Approximate Interval Between Onset and Death
6876U,	ifficate be executed g physician and as the burial-transit	cal	resulting in death) Last	Due to (or a	s a conseq									
	at the death certificate by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ੴ 0 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	Ectopic pro					2	3d. Date of deli Month	very Day Year
coras, r	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition ASCITES	ns contributing to death	but not res	ulting in the ur	nderlying ca	ause give	n in Part I.					the cause of death?
Ē	The ate ha	Completed	HYPERTENSION								24a. Was a autops perform 1 ☐ Yes	ned?	prior to death?	topsy findings available completion of cause of 2 No
VII	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	~		Check only on			
5	Phy raid raid	- To	1 Yes 2 No 27. Manner of Death	1 Inpat 28a. Date of Inj (Month, D		ER/Outpatien 28b. Time of		A	4 🗆 NU		5 Reside		Other (Spec	ify)
\leq	e Hospitel or Attending F 24 hours after death. • Funeral Director: After etely filled in by the funera	Certification:	1 🔄 Actival 5 🗆 Pending 2 🗀 Accident Investig 3 🗀 Suicide 6 🗀 Could n 4 🗀 Homicide determi	ot be 28e. Place of Ir		Injury ome, farm, stre	М		? ′es 2 □ l		Location (Si City or Town	reet and n, State)	Number or Ru	ral Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Discompletely filled in	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the besi examiner: On the basis and manner s	of examinal	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, and th occurred	I due to the ca at the time, d	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)
٨	To the To the Complet	X	29b. Signature and title of certifier				290	License	number 0061	446	2		signed (Month	
L	(10)		30. Name and address of person v KALAISELVI	AYYANAR	M.D.	3001		ITAL .	DRIVE	, CHE	VERLY	MD	20785	
	Sta	_	31. Date filed (Month, Day, Year) APR 0.4 200	32. Regist	rar's Signa	turo	-							

EIDIG, RUM

	Í	For per Fun.Dir.State of Maryland / Delastate AACo.Health Dept. BEM Co.	partment of Health and ertificate of Death	Mental Hygie	ene	
Dhusia		1. Decedent's Name (First, Middle, Last)		O Ditt of Doub	2005	3. Time of Death
Physic /Medi		Ruth Heidig		Month March	39, 2005	1:31AM
Exami	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	1
		Doctors Community Hospital	Lanham		Prince Ge	
Funeral Director		5. Social Security—16 18 6. Sex 1 M 2 TF 7. Age (In yrs. last birthda 1973—16—1259 81 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min		Year) 9. Birth Cou 23 New	place (State or Foreign Intry) York
laryland show		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Maryland If show	ō	Maryland Prince Georges Bowie				1 ▼Yes 2 □ No
th the M or 28e-f	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?
death with the ms 23a or 28e	a	3109 Tinder Place	20715	US	SA	
ĕ <u>₽</u> ₹	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 ∀ Yes 5 □ Yes 2 □ Yes 2 □ Yes 2 □ Yes 2 □ Yes 3 □ Yes	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
hours after tural; or Ite	d by	3 XWidowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	ite
Z 13-0030 ithin 72 hours aft ie. an "natural", or Medical Exural	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gin	edent's Usual Occupation re kind of work done during most of wo DO NOT use retired)	rking 16	3b. Kind of Business/li	ndustry
within and the man	ф	College (1-4or 5+)	Maker		O II	
filed wi Hygien Ither th		17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	Own Home	
Maryland 212 nd 2 should be filed within th and Mental Hygiene. 27 is marked other than rtraumatic event, the Maryl	To Be	Edward F. Hagan	Florenc		oden Sumame)	
shoul nd Ma mari	۳		ling Address (Street and Number or Ri		City or Town State 7	n Code)
MC 2 Inth all 11th all 127 is ritrau			Tinder Place Bow			D 000e)
DAILIMOCE, Mispermit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any Injury or other tragges.		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or T	own, State
Page Nent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Huntt Cr	· · · · · · · · · · · · · · · · · · ·	30/2005 Wa	aldorf, MD	
Salfimore, semit. Pages 1 a Department of Hea mportent: If Item nny Injury or othe			22. Name and Address of Facility Ro	bert E. Ev	vans Funer	al Home
Demi			6000 Annapolis Ro			
Physician (icate be executed by Sician and by Sician and its the pural-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	l Infarction viery disease	se_		Onsel and Death One heur 7 years
the death certiff the attending the attending	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
ires that signed by I be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to t	
w requir been si should	etec			T Yes	2 No 3 Prob	pably 4 Unknown
The law requires to the law requires to the law been signed page 2 should be contact.	Completed			24a. Was an autopsy performed	d? prior to co	psy findings available impletion of cause of
sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?		th (Check only one)		
This raid dia	lon: To	1 Tos 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?	ome 5 Residence 28d. Describe how i	e 6 Other (Specifinjury occurred	y)
or Attendater death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
To the Hospitel Within 24 hours a To the Funerel completely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or is and manner stated	th occurred at the time, date and place avestigation, in my opinion, death occu	, and due to the caus	e(s) and manner as s and place, and due to	ated. the cause(s)
o the	Me	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month,	
⊢≯⊢ŏ		Mosspfa Sherma, MD	D43690	1	1	905
		30. Name and address of person who completed cause of death (Item 23a) (Type Moustaff SHAMMA, Docto	RS Comm Hosp. La	inham, r	ND	
Sta Registr		MAR 3 0 2005	foods	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	ıryland		artmen rtificat					giene	005	i 12878
	Physic	ian	Decedent's Name (First, Middle, Last	,							2. Date of Dea Month		Von	3. Time of Death
	/Med		Lillian			,	,				March	29,	200.	5 11:00 p M
7	Exami	ner	4a. Facility Name (If not institution, give						Location of				County of De	
			Mariner Healthca 5. Social Security Number 6. Se		Marine lead	4 i 4 i 1 i 1			Sprin	_			ntgome	
	Funeral Director			M 2√F 7. Age	(In yrs. last	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Nov. 11	Year)	9. B	irthplace (State or Foreign Country) ennsylvania
	yland		10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	a-fsl	to	Maryland Montgome	ry	Wheat	on								1 XYes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	Country?
	238		12214 Kendall Cour	t			2	0902				U.	S. A.	
	er de	Funeral		Was Decedent E Armed Forces?		13.	Was Deced	dent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)			nerican Indian,
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 N If Yes, Give Year or Dates:	∘ WW 2		1 ☐ Yes 2		Specify:		, ,	-		White
9	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturat", or itams 23a or 28a-f show avent, the Medical Experient must be notified at	ed b	15. Decedent's Edu			6a Decey	dent's Usua	1 Ossupa	tion					
15	n na	Completed	(Specify only highest grad	e completed)		(Give	kind ol wor DO NOT us	rk done d	urina most	t of worki	ng	16b. Kin	d of Busines:	s/Industry
212	d with giene	E	Elementary/Secondary (0-12) 12 Years	College (1-4or 5-	+)		retar	,				Fed	eral C	Government
פנ	e filed within al Hygiene. I othar than ' vant, I'n We	Be C	17. Father's Name (First, Middle, Last)					-	18. Mothe	r's Name	(First, Middle,			overiment
/lar	should be nd Mental markad o matic ava	ToE	Abraham Finkelma	n					Ev	a Mi	.11man			
lan	es 1 and 2 should b of Health and Ment fitam 27 is markac r other traumatic a		19a. Informant's Name/Relationship (Ty		1	9b. Mailir	g Address	(Street a	nd Numbe	r or Rura	l Route Number	r, City or	Town, State,	Zip Code)
Σ.	and salth n 27		Robin Imber - Dau	ghter ——————		1221	4 Kend	da11	Cour	t, W	heaton,	Mar	yland	20902
ore	of He itar		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	Removal from State	20b. Place ceme	of Dispo	sition (Nam natory or ot	ne of ther place	9)	D	ate	20c. Loc	ation - City o	r Town, State
Ë	Pag ment tant: jury o	-	`4 □ Donation 5 □ Other (Specify)	iomovai nom otato	Md.		can Co		-			Che1	tenham	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service License			Da	. Name and anzans	d Address Sky-(s of Facility Goldb	erg	Memoria	1 Ch	apels,	Inc.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused t	the death D	1 1	170 D	~ ~ 1	111.	n -: 1	D . 1		, Mary	land 20852
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Meta	stati	c Car			, 30011 43 (respiratory and	est,		Interval Between Onset and Death 6 Weeks
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0	e exe ian ai urial-t	EX	resulting in death) Last	Due to (or as a	consequenc	e of):								
8760,	death certificate be executed e attending physician and of for use as the buriat-transit	dical		l										
<u> </u>	e as t	Med	IF FEMALE:		- 20									
Вох	eath certif attending for use as	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2	☐ Fetal dea		Ectopic pre					23	d. Date of de	,
		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death	5 🗆	Other (spe	ecify)					Month	Day Year
Δ.	law requires that the di as been signed by the 2 should be detached	Ph	Part II. Other significant conditions con	tributing to death but	not resulting	in the un	derlying ca	USA Alver	n in Part I		23a Did toh	2000 110	anatributa t	o the cause of death?
ds,	sign d be	db	Chronic Destru					uso girei	THIT GIVE.			s 2 🗆		robably 4 \(\begin{array}{c}\text{Unknown}\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
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Vital Records,	면 무 면	Completed	7 III CIII LU								24a. Was an autops perform	у .	24b. Were at prior to death?	utopsy findings available completion of cause of
ta			25. Was case referred to medical								1 ☐ Yes 2	No	1 ☐ Yes	2 □ No
		o Be	examiner?	ospital: 1 Inpatient	2 ER/0	Dutnationt	3 DOA	Other			(Check only one		70" (5	
Division of	g Physer this seral di	F ii	27. Manner of Death	28a. Date of Injury (Month, Day	28b	. Time of		c. Injury a			8d. Describe ho			icity)
0	Attending er death. ector: After by the funer	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Worth, Day	(641)	Injury	М		r es 2 🗌 N	lo				
<u>S</u>	er de recto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	y - At home,	farm, stre	et, factory,	office		2	8f. Location (Str.	eet and /	Vumber or R	ural Route Number,
Ω	spital or a ours after naral Dire filled in by	Cer								lik	City or Town	,		
	24 h Fur stely	Medical	29a. Certifier 1 [™] Certifying Phys (Check only one) 1 [™] Certifying Phys 2 Medicel Examin	icien: To the best of er: On the basis of e and manner state	Kanimation a	ge, death and/or inv	occurred at	t the time in my opir	, date and nion, death	place, a	nd due to the ca d at the time, da	use(s) ar	nd manner as ace, and due	s stated. to the cause(s)
	I o tha Hos within 24 h To tha Fur completely	Me	29b. Signature and title of certifier				29c.	License i	number		29	d. Date s	igned (Mont	h, Dey, Year)
	0		> Structure -	1/2 A	e,,,	W .:		D005	7630					
	5		30. Name and address of person who cor	mpleted cause of dea	ith (Item 23a) (Type. F	rint)						h 30,	
	9		Anuradha Arun,	M. D. 103	301 Ge	orgi	a Ave	nue,	Suit	e 20	9, Silv	er S	nrino	Md 20002
	Sta Registr	_	31. Date filed (Month Par Year) 1 2	005 32. Registrar	s Signature		rade							20902

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Garna (NMN) Johnson April I, 2005 8:10A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 313 Bridge St. Mardela Springs If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Director Yrs. June 26,1909 Tennessee 579-48-807 95 Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28e-f ehow the Medical Examinar must be notified at MD Wicomico Mardela Springs 1 TYes 2 XVo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 313 Bridge St. 21837 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours efter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Magazine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 end 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any julyy or other treumatic event once. Mary Margaret Long Marion D. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21837 **Leland Smith** 313 Bridge St., P.O. Box 239, Mardela Springs, Md. 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem, 4-1-05 Frankford, DE `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FAILURE TO THRIVE /28 lo5 /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760. Physiclan/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live birth 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed ves 22 No 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D58755 APRIL 1,2005 ddress of person who completed cause of death (Item 23a) (Type, Print) K. ARZADON, 9714 HEALTHWAY DZ., BERUN, MD 21811 GLEKIN 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			1- State Registrer	e of Maryland	•	artment of Hea tificate of De			jiene eg. No. 201	N5 12000
	Physici /Medic		Decedent's Name (First, Middle, Last) Ross Mic.	hael Jones				2. Date of Dea Month April	Day Y	'ear 005 12:53 p ^M
	Examin Funeral Director		4a. Facility Name (If not institution, give street and 235 Fawn Drive 5. Social Security Number 219-11-5580 6. Sex	7. Age (In yrs. Ia	st birthday) Yrs.			8. Date of Birth (Month, Day DEC 29,	4c. County of Ceci.	
	ש		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
•	ith the Mar or 28e-f sh	Director	Maryland Cecil 10e. Street and Number	E1	kton	10f. Zip Code			0g. Citizen of Wh	•
. 980	s within 72 hours after death with the Marylend lien. Then "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at	by Funerai	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S d Forces? 'es 2 X No is, Give or Dates:		Vas Decedent of Hispa f Yes, specify Cuban, i □ Yes 2\nabla No	anic Origin? (Spe Mexican, Puerto I Specify:	ocity Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc. White
Maryland 21215-0036	d within giene. rr then *	Completed	15. Decedent's Education (Specify only highest grade completed in the comp	ted) ge (1-4or 5+)	(Give	tent's Usual Occupation kind of work done during NOT use retired)		ng	16b. Kind of Busin	ness/Industry
land	should be filed id Mental Hygi marked other matic event,	To Be C	17. Father's Name (First, Middle, Last) Carl Dan Jones			18		(First, Middle, Stake	Maiden Sumame) Y	
Mary	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print) Carl Dan Jones/Fathe	i i		g Address <i>(Street and</i> Fawn Drive			-	
Baltimore,			20a. Method of Disposition 1 (X Burial 2 □ Cremation 3 □ Removal for 4 □ Donation 5 □ Other (Specify)	rom State cer	netery, cren	sition (Name of natory or other place) emetery	April 2005	eate 8,	20c. Location - Ci Chesapea Maryland	
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	uho	22 H 1	Name and Address of icks Home 03 W. Stoc	for Fune kton Str	erals, Freet, El	A. kton, Ma	ryland 21921
	Physician /Medical		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. Iltiple gunsh	stwound	er the mode of dying, s				Approximate Interval Between Onset and Death
68760, <	fircate be executed Thysician and Is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e to (or as a conseque	ence of):					
O. Box	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	in the past 12 months?	, outcome of pregnan ive birth 2 ☐ Fetal of regnant at time of dea inknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
۵.	tuires that signed b	by	Part II. Other significant conditions contributing	to death but not result	ting in the ur	nderlying cause given i	n Part I.	23e. Did to	/	ute to the cause of death? Probably 4 □Unknown
of Vital Records,		Completed						24a. Was a autop:	sy pric med? dea	ere autopsy findings available or to completion of cause of auto? Yes 2 \(\square\) No
f Vita	ysicien is certifi director	To Be	25. Was case referred to medical examiner? 1 🕱 Yes 2 🗆 No Hospital:	1 ☐ Inpatient 2 ☐ E	R/Outpatien	Othor	6. Place of Death			(Specify) scene
Division o	or Attending ifter death. Director: After in by the fune	Certification:	1 Natural 5 Pending investigation 3 Scicide 6 Could not be 28e. F	Month, Day Year)	28b. Time of Injury Cund (2:- ne, farm, stre	Work? 1 □ Yes eet, factory, office	2 2 No	28f. Lobation (S City or Town	shot and Number of State)	or Rural Route Number,
	Fur 4	edical (29a. Certifier (Check only one) 1 Certifying Physician: To 2X Medicel Examiner: On the and of the control of the control one)		ledge, death	occurred at the time,				
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. License no		2	9d. Date signed (I	
	1		30. Name and address of person who completed LING LI, MIP	cause of death (Item ;	23a) (Type,	Print) 111 Pen	n Street	Balti	more, Ma	ryland 21201
	Sta		31. Date filed (Month, Day, Year) 3	32. Segistrar's Signatu	k /	and I				

05-2396 B.K.S MATTH

S HEW J.	. J <i>I</i>	ACK	Please SON 1 - For State Registrar		aryland / Depa		Health and N	-	Are Legible	12881
	ysicia		1. Decedent's Name (First, Middle, La		ACKSON, II			2. Date of Do Month	eath Day Yea	3. Time of Death 1815 P M
1	ledic amin		4a. Facility Name (If not institution, given 47 RAILROAD AVE	re street and number)		4b. City, Town, NORTH	or Location of Death	APRIL	5, 2005 4c. County of De CECIL	
Fun Direc			218-51-9351	Gex 7. Ag	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi (Month, Do MARCH 2		irthplace (State or Foreign Country) RYLAND
/aryland	ed all	ō	Usual Residence of Decedent 10a. State 10b. County MARYLAND CECIL		10c. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ath with the Marylan	I be notif	Direc	10e. Street and Number 44 CEDAR HILL C	TPCI F	NORTH E	10f. Zip Code 2190	1		10g. Citizen of What (Country?
er de	Xar III er m	by Funerai	11. Marital Status 1 ▼Never Married 2 ■ Married 3 ■ Widowed 4 ■ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No		Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No Rican, etc.)		erican Indian,
Z15-UU36 thin 72 hours aff e.	Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	lent's Usual Occup kind of work done DO NOT use retire	pation during most of worked)	king	16b. Kind of Busines	
N P D b			1		STU	JDENT	T		ELEMENTA	RY
2 e e		To Be	17. Father's Name (First, Middle, Last MATTHEW JASON J				1		, Maiden Sumame) OBINETTE	
Marylan d 2 should be th and Mente 7 is marked	other traumatic	-	19a. Informant's Name/Relationship (REBECCA A. ROBI	Type, Print)			t and Number or Run	al Route Numb	er, City or Town, State, EAST, MARYI	
ges 1 an t of Heal	or other	1	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	<u> </u>	20b. Place of Dispos			Pate 8,	20c. Location - City of	
Dalfilmor permit. Pages Department of I Importent: If it	eny injury		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licentary)	ý)	METHODIST	CEMETER	RY 2005 Es of Facility FUNI			, MARYLAND
Physic / Medi Examin	ian cal ner	ai Ex	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause. First lind strying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c.	the death. Do not ente	or the mode of dying	ng, such as cardiac	KEET, EJ	LKTON, MARY	LAND 2121 Approximate Interval Between Onset and Death
the death certificate by the attending physical		Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other <i>(specify)</i>	у	***	23d. Date of de Month	blivery Day Year
v requires that the deben signed by the characters and the deben signed by the characters are the characters and the characters are the characters	2 .	2	Part II. Other significant conditions o	ontributing to death bu	at not resulting in the un	derlying cause giv	ven in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
: The law requir	4	Completed							an 24b. Were a prior to death?	utopsy findings available completion of cause of
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funered Director After this certificate has been signed by the attending physicians within 24 hours after the triangent of the funeral director page 2 should be deathed for use or this certificate.		0	25. Was case referred to medical examiner? 1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b. determined	1/0/00	y 28b. Time of	28c. Injur Wor — M 1 [y at k? Yes 2 No	me 5□Resid 28d. Describe r Subject	dence 6 Vother (Spenow injury occurred Strull by Street and Number or R	tonia
To the Hospitel or Attendi Within 24 hours after death. To the Funerel Director: A			(Check only 21 Amedical Exam	vsician: To the best o	f my knowledge, death examination and/or inve	traile	me date and place :	17RC411	ed And, (ec	stated.
o the F o the F		Medical	one) 29b. Signature and title of certifier	and manner sta	ted.	29c. License			date and place, and due 29d. Date signed (Mont	
F ≤ F ∂			· Zalville	al AC			CME		APRIL 6, 2	
	1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, P		enn Street	Balti	more, Mary	
Reg	State istra		31. Date filed (Month, Day, Year) APR 1 5 2	005 32. Agistra	r's Signature					21201

			riease	rype or Print in E			-	•	
			1 For State	State of Marylan	· ·		Mental Hygien	9 005	12882
			Registrar		Certificate	of Death	Reg. N	lo.	12002
	Dhusia		1. Decedent's Name (First, Middle, L.	ast)			2. Date of Death		3. Time of Death
	Physic /Medi		DORRINE	V. JOHNS	2001		March 3	o 2005	5 12:45 PM
1	Exami		4a. Fecility Name (If not institution, gi	ve street and number)		wn, or Location of Death		c. County of Deat	
			202 GRave	Rual Roc	20 G	Rasonvil	10 1	Ducer	Amma's
	Funeral			Sex 7. Age (In yrs. I	ast birthday) If Under 1	Year If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Director		220-16-2741	10 M 20 (17	Yrs. Months	Days Hours Min.	(Month, Dey, Yee)	37 19	ountry)
1	D		Usual Residence of Decedent				160,10,11	3 / ///!	car gravia
h :	Maryland -f ehow [list at		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
Y:	Ma-1-	io	MD Quee	in Anne's	GRASONV	11/0			1 Yes 2 No
χ	with the Marylan a or 28a-f ehow be civilities at	Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·	10f. Zip C		10g. C	itizen of What Co	puntry?
3	death with the ms 23a or 28a frivat be noti	O ie	202-GRave	I RUN ROa	d	21638		1154)
1	urs aner death v al', or Items 236 Examiner nast	Funeral	11. Marital Status	12. Was Decedent Ever in U.		nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	ncan Indian.
ပ္	or Ite		1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No			Rican, etc.)	Black, White	
8	nours aner ural', or Ite al Exa⊡ine	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify: 8	ack
	natur lica	Completed	15. Decedent's E	ducation	16a. Decedent's Usual	Occupation	16b.	Kind of Business/I	
215	- 3	pie	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work life. DO NOT use	done during most of work retired)	king	_	,
21	Hygiene. Other than	ПО	/ ()	Oblige (1-401 54)	C.o	OK		Fas 6	itation
פַ	be filed with tal Hygiene. of other than event, the M	Be	17. Father's Name (First, Middle, Las.	1)		18. Mother's Nam	e (First, Middle, Maide	n Sumame)	, 10,,011
<u>a</u>		ToB	Farly:	Tohnson		1:110	1100	Paule	
Maryland	s I and z should be filem zz is marked other traumatic ev	-	19a. Informant's Nam - elationship		19b. Mailing Address (S	Street and Number or Rui	al Route Number City	or Town State 7	in Code)
2 5	trat		Touco Ann	Johnson	Pro Prov	454 GB	C1 S 0 10 1 1	1. 11	211.30
စ် ဒ	other tr		20a. Method of Disposition	20b. PI	ace of Disposition (Name	of	Date 20c. I	Location - City or 1	Town State
Baltimore,			1 Burial 2 Cremation 3	☐Removal from State	emetery, crematory or other	or place)	-1-1-0	one-entro	t d
# °	Department of mportant: If mportant: If any injury or once.		`4 □Donation 5 □Other (Speci	101	-yan's Cem	etery +/	0/03 GR	asonvi	Ile, MD.
Ba	Depa Impo any i		21. Signature of Funeral Service Lice	O A DA	22. Name and A	Address of Facility Lune Ral	Home, P. A	7.	
	101 4 4		Junear	C. Steway		2 Shinaton	Stillamp	ridge, /V	10,21615
			23a. Part Enter the disease, or con shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not enter the mode of	of dying, such is cardiac	or respiratory arrest,	1	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	Alcoholis	liver 1	ducto			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		we w			6 months
E	xaminer		Constant the flat and date as	b					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):				
athe	d ansii	Examiner	Cause (Disease or injury that initiated events						
), exe	ial-tr	Exa	resulting in death) Last	Due to (or as a consequ	ence of):				
760,	/sicia	cal		d					
Records, P.O. Box 68760, The law requires that the death certificate be execut	attending physician and for use as the burial-transit	edi							
Box	ngu esn	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan				23d. Date of deliv	
m f	atte	cia	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de				Month	Day Year
O E	y the	ıysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown		97			
<u>م</u> ق	igned by the atter be detached for u	P /	Part II. Other significant conditions	contributing to death but not resul	Iting in the underlying caus	se given in Part I.	23a. Did tobacco	use contribute to	the cause of death?
Records,	sign d be	d by			3	3			bably 4 Unknown
Ö	been s	ete					10,163 2	30,10	Dadiy 4 Grikilowii
e ec	has l	Completed					24a. Was an autopsy		topsy findings available ompletion of cause of
	pag	S					performed?	death?	2 □ No
Vital	ertific octor.	Be	25. Was case referred to medical examiner?			26. Place of Deat	n (Check only one)		
of Vita Physician:	this o	2	1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA	Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Spec	ify)
	ter ti		27. Manner of Death 1 Anatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c.	Injury at Work?	28d. Describe how inju		
Division or Attending	after death. Director: After in by the funer	atle	2 ☐ Accident investigation	n	М	1 Yes 2 No			
Vis	er de ecto by th	<u>≓</u>	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ne, farm, street, factory, o	ffice	28f. Location (Street ar	nd Number or Rui	ral Route Number,
	s afte	Certification;		building, etc. (Specify)			City or Town, State	a)	
Division Hospital or Attending	hour Iner		29a. Certifier 1 Certifying Pt	ysician: To the best of my know	riedge, death occurred at t	he time, date and place,	and due to the cause(s) and manner as:	stated.
ž Ž	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Exar	niner: On the basis of examination and manner stated.	on and/or investigation, in	my opinion, death occurr	ed at the time, date an	d place, and due t	to the cause(s)
To the	withi To tl	Σ	29b. Signature and title of certifier	-7 -	29c. L	cense number	29d. Da	ite signed (Month,	Day, Year)
			1/1/1/	Le the	< MS	061829		3/201.	1 1
		1	30. Name and dress of person who	completed cause of death (Item	23a) (Type Print)	,		1 2016	//
			REYNALDO LEE-	Lears a IT	23a) (Type, Print) 2108 D. D.	- 6 D	016	ad h	2.1.6
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	na 10 Utiv	c (hester	1111) 2	-(6/1
	Registr			32. Registrar's Signatu	He Rocall !	1			
		100		Tax Parties	Line Talling State				

			Please	Type or Print in I			•		
			For	State of Marylar	•	ent of Health and	Mental Hy	giene) nn 5	12000
			For State Ragistrar		Certific	ate of Death		Reg. No.	12003
			1. Decedent's Name (First, Middle, Las	1)			2, Date of De Month	eath , Day Year	3. Time of Death
	Physici /Medio		Mildred	ANNA	JOV	1e5	Marc		5 2:35 pm
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location of Dear	th	4c. County of Dea	
			6323-Oce	in (fate)	May!	Easton		Tall	0+
	Funeral		5. Social Security Number 6. Se		last birth (ay) If Un Mont	der 1 Year If Under 24 Hrs		rth 9. Bir	thplace (State or Foreign ountry)
	Director		216-40-3702 1	JM 2127F 6	2 Yrs.	lis Days Hours Will	Oct. 3	201942 N	Taryland
	9		Usual Residence of Decedent					1	1
\neg	how how		10a. State 10b. County	10c. Ci	ty, Town or Location	, ,			10d. Inside City Limits
7	Ma Ma	ᅙ	MD Talk	toot		aston			1 ☐ Yes 2 ☐ No
Υ.	h th	Ē	10e. Street and Number		10f.	Zip Code		10g. Citizen of What C	ountry?
3	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28e-f show the Madical Examiner rust be notified at	by Funeral Director	6323 OC	ean (rat	eway	21601		US	A
9	deat deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		scedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or N	o- 14. Race - Am Black, Whi	
9	after or Ite	교	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 12 No If Yes, Give		s 20 No Specify:	to moun, etc.)		10, 610.
ဗ္ဗ	ours al',	<u>5</u>	3 Widowed 4 Divorced	Year or Dates:	10.10	s 201140 Specify.		Specify: B	lack
21215-0036	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Decedent's U	Isual Occupation	orkina	16b. Kind of Business	/Industry
2	nlo.	pje	Elementary/Secondary (0-12)	College (1-4or 5+)		work done during most of wo T use retired)			0 . 1
7	d with giene.	no.			17011 /	-acility Su	Per Visón	MEMOR:	al bridge
	be filed tat Hygie d other event,	Be (17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	e, Maiden Sumame)	
<u>a</u>	Mental Mental arked c	ToE	Millis B.	Scott:	SR.	Anr	na La	Rue SA	1:th
Maryland	2 should I and Meni is marke eumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addi	ress (Street and Number or R	ural Route Numb	ber, City or Town, State,	Zip Code)
	1 and 2 Heelth a em 27 is		Brenda L	Wonden	P.O.B.	0x 2272 E	aston	Marylan	ud 21601
e e	item oth		20a. Method of Disposition		Place of Disposition (cemetery, crematory	Name of or other place)	Date	20c. Location - City or	Town, State
Ë	Pages nent of I ent: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State /)	aradise	Cemetery 4/	2/05	Trappe,	Maryland
Baltimore,	- EE -		21. Signature of Funeral Service Licen			1.11	1	' /	1100.
ä	Dermi Depa Impo any Ir		1 Janolle	C. Serry	/ He'w	Ry Funeral	N Sty	Jambri do	@ MD. 2/61
			23a. Part1/Enter the disease, or comp	olications that caused the dea	th. Do not enter the r				Approximate Interval Between
	Dhamisian		shock, or heart failure. List only i	one cause on each line.	hi co				Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a consec	THE CO	ncer			years
	Examiner			At dim	duerice ci).	206,00			weeks
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760,	ie be executed /sician and e burial-transit	cai	l l	4					
687	phy:			· · · · · · · · · · · · · · · · · · ·					
×	certii ding	M/	IF FEMALE:	23c. If yes, outcome of pregn	ancy			23d. Date of de	livery
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No	1 Live birth 2 Feta 4 Pregnant at time of c		c pregnancy (specify)		Month	Day Year
<u>Р</u> О	the d	ysi	1 ☐ Yes 2 D No 9 ☐ Unknown	9□ Unknown		(4,000,00)/			
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medi	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	ng cause given in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
ds	sign d be	d b					1 🗆	Yes 2□No 3□P	robably 4 Unknown
Ö	requiper /	Completed					24a. Wa:	Oth Ware	utopsy findings available
š	6 taw has 16 2 t	mpi					auto		completion of cause of
<u></u>	cate						1 ☐ Yes	2 No. 1 □ Ye	s 22 Ne
Division of Vital Records,	lcien certiff ector	Be	25. Was case referred to medical examiner?	Hospital:		Othor	ath (Check only		
of	this al dir	2	1 Yes 2 No	1 Inpatient 2	ER/Outpatient 3 28b. Time of	DOA 4 Nursing		idence 6 Other (Spentage) to the following formula in the following fo	ecity)
Ĕ	ing After uner	ion	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work?	200. Describe	now injury occurred	
S	tend jeath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be				29f Loostian	(Street and Number or F	tumi Pouto Number
\leq	or At fter (Sirec in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	скогу, опісе		own, State)	urar noute reamber,
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	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowiner: On the basis of examination and manner stated.	ation and/or investiga	tion, in my opinion, death occ	e, and due to the urred at the time	, date and place, and du	e to the cause(s)
	thin S the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mon	th. Dav. Year)
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,			, ADOUL	w	- 00-1/5	200210	5 /	0/0//0	
			30. Name and address of person who			. D MT	21601		
			Damian Sooklal, 31. Date filed (Month, Day, Year)	32 Possistraria Sign		ne, Easton, MI	21601		
	Sta Registi		APR 0 1	2005	Is don				

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Month Year Kathleen Creasy Kemp 31, 2005 12:48P M /Medical March 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehabilitation Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🗙 F Hours 1 1 / 12 / 1917 203-05-3467 Director 87 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r then "naturel", or Items 23s or 28e-f shov the Medical Examinatings be rotified at 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No MD Worcester Berlin 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11647 Beauchamp Road 21811 **USA** filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home treumetic event. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Pages 1 and 2 should be and Mental Bowman Roadarmel Mary Creasy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other treu once. Joseph Kemp (Son) 11647 Beauchamp Rd. Berlin, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩Burial 2 Cremation 3 Removal from State New Rosemont Cem. 4 Donation 5 Other (Specify) 04/04/2005 Bloomsburg, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part1. Enter the disease or complications that badset shock, or heart failure. List only one cause on each line ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Olvision of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 certificate 1 Yes 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ٩ 2 No Other 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Mursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Netural 5 Pending investigation Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signardre 200 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 5 2005

Kathleen

Kemp,

Drie

Registrar's Signature

			1 - For State Registrar	State of	f Maryland		artment rtificate					giene ()	05	12885
	Dhysia		1. Decedent's Name (First, Middle,	Last)							2. Date of De	ath		3. Time of Death
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	Examir		4a. Facility Name (If not institution,	give street and num	nber)		4b. City,	To wn , or	Location	of Death		4c. Cou	nty of Death	
			326 Hannes Str						er Sp				Mont	gomery
	Funeral			i.Sex 1 1 3 tM 2 □ F	7. Age (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Ye <i>ar)</i>	9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		93	TTS.					Aug. 23			ania
	/land		10a, State 10b. County		10c. City,	Town or Lo	cation						T	10d. Inside City Limits
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	e ems	ner	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. V	Vas Decede	ent of His	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	lace - Amer	
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ë	be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. It he medical Examiner must be notified at event, the Medical Examiner must be notified at	d b	3 X Widowed 4 □ Divorced	Year or Da	tes:							Spec	ciry: Wh	ite
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ar _S	shou and N s mai	_	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	I Route Numbe	r, City or Tow	m. State. Zi	p Code)
Ž	and 2 laith a 27 i		Ann Kitsoulis/	Daughter							lver Sp			
ore C	of He ritem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		20b. Plac	e of Dispos	sition (Name	e of her place) [il 4,	20c. Location		
Ĕ	Pag ment ent: I		`4 □ Donation 5 □ Other (Spe		ruico	of Hea			1	_		Silver	Sprin	ng,Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28erf show any injury or other treumetic event, the Medical Examiner must be inclined at once.		21. Signature of Funeral Service Lic	ensee		Fr	Name and	J.	Co11	ins	Funeral	Home	Inc.	
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/	Vic		MAKE	pell				D098	34			Marc	h 31,	2005
/	, (0		30. Name and address of person who Barry Rosenbaum	, M.D.	3720 Fa	rragu	t Ave	nue,	Kens	singt	ton, MD	20895		
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			State of Maryland / Del 1- State Registrar amend item #18 per fh g843 596	partment of Health and Na <i>rtificate of Death</i>		ene 005 2880	5
			1. Decedent's Name (First, Middle, Last)	D/V)_JB	2. Date of Death	3. Time of Death	3
	Physici /Medi		LESTER LEE KINTNER		March	17 2005 8:20 P	М
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			Holy Cross Hospital	Silver Spring		Montgomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		(ear) 9. Birthplace (State or Fore	ign
	Director		348.16.6452		July 8,	1925 Belleville, I	L
	land		10a. State 10b. County 10c. City, Town or	-ocation		10d. Inside City Limi	its
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	r 28g	Director	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Country?	
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altimore,	of Health of Health item 27 I		20a. Method of Disposition 20b. Place of Disp			c. Location - City or Town, State	
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Balti	permil. Pages 'Department of H Important: If ite any injury or ot					INC. ver Spring, MD 2090	
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8760,	cate be executed physician and the burial-transit	dicai	d				
9 ×	death certific e attending p id for use as	⊕ ⊢	IF FEMALE: 23c. If yes, outcome of pregnancy	•			
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n of	Attending Physician: r death. ector: After this certifics by the funeral director.		27. Manner of Death 1 ⚠Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury		28d. Describe how i		
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	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the Funeral Director Completely filled in the Complete of	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)	
			Vercolano	MD20082	=	3 30 05	
	20		30. Name and address of person who completed cause of death (Item 23a) (Type,			1-01-0	
_			Daya Sharma, M.D, 106 Irving Street,	N.W., Washington,	D.C. 200)18	
	Sta		31. Date filed (Mark Bay, 3a1 2005 32 registrar's Signature	neile)			
	Registra	ir	Light of the				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year Willie Mae Kingsberry 24 2005 /Medical March 11:30 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4915 Eastern Ave., #407 Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Director Yrs. 151-28-8982 May 1. Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "naturel; or items 23e or 28a-1 show ary or other traumatic event, if a Medical Examinar must be rediffed at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 11 Yes 2 □ No Maryland Prince George's Hyattsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4915 Eastern Ave., #407 Completed by Funeral 20782 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ₩idowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Nurses Aide Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry G. Rogers ဂ္ Rebecca Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Sweeney, Sr. - Son 11412 Old Lottsford Rd., Mitchellville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Lee's Crematory ` 4 □ Donation 5 □ Other (Specify) 4/1/2005 Clinton, MD 21. Signat re of ru eral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Menson 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ancreatic cancer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) P.0. the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ρ Completed 1 ☐ Yes ≱ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🐉 No 2 this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) March 31, 2005 30. Name and address of person who completed cause of wath (Item 23a) (Type, Print) Veter Edenery 14300 Gallant Fox Care \$100 M.D. BOWGE MO 31. Date filed (Month, Day, Year) 32. Registrar's Signa APR 0 4 2005 Registrar

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Baltimore,	permit. Pages 1 Department of He Important: If itan any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ace of Dispos imetery, crem snadar	, Russ:	ia	April 200	5	20c. Location Krasnac	lar, R	
Ball	permit Depart Import any in		21. Signature of Funeral Service Licen	e Vol				wasn	ington	ol Fund nsin Av , D.C.	20007	me W.	
	Pnysician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complication, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	one cause on each iir	a consequ	ence of):				Cava Tass		ılas	Approximate Interval Between Onset and Death
<u></u>	icate be executed physician and s the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	ence of):							
.O. Box 68	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3 🔲	Ectopic pregn Other (specif					ate of delive	ery Day Year
rds, P	quires that an signed build be det	by	Part II. Other significant conditions co	ontributing to death bu	ut not resul	ting in the un	derlying caus	e given in Pa	rt I.		bacco use co es 2□No	ntribute to th	ne cause of death?
al Reco		Completed								24a. Was a autop: perfor 1 X Yes	sy	prior to cor death?	psy findings available mpletion of cause of 2 No
Division of Vital Records, P.O.	ding Phy I. After this funeral c	ation; To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	v [2	R/Outpatient 28b. Time of Injury	28c.	Other	Nursing Home	Check only or 5 Tesid Reside	ence 6 □Ot		v)
Divis	Ital or Attendrs after deatlal Director;	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	iry - At hon . <i>(Specify)</i>	ne, farm, stre	et, factory, off	ice	28	8f. Location (Si City or Town	treet and Num n, State)	ber or Rura	l Route Number,
	To the Hospital or At within 24 hours after of the Funeral Direct completely filled in by	Medicai	one)	rsicien: To the best of iner: On the basis of and manner sta	examination	ledge, death on and/or inve	occurred at the estigation, in r	ne time, date ny opinion, d	and place, an leath occurred	d due to the c	ause(s) and mate and place	anner as st , and due to	ated. the cause(s)
	2 6	2	29b. Signature and title of certifier	llow	ud		29c. Lid	OCME	er		^{9d. Date sign} larch 2		
	8		30. Name and address of person who c	tulan	wd	За) (Туре, Р	111	Penn	Street	Balti	more,	Maryl	and 21201
	Sta Registr	- 37	31. Date filed (Many) Bay, Sar 2	005 32 negistra	r's Signatu	1 Apr	wer						

			1 - State of Maryland / Department of Certificate o			ene 005 12889
	Physic	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	/Medi	cal	Sarah Elizabeth Knott			31,2005 1:35 p M
	Examir	1er		, or Location of Death		4c. County of Death Prince George
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea	ar If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Fornism
	Director		213-82-5226 1 M 2 M F 53 Yrs. Months Day Usual Residence of Decedent	s Hours Min.	$\text{July}^{Month} 10^{\text{pay}}, 1$	951 Maryland
	yland now		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fst	ctor	Maryland Charles Waldorf			1 ☐ Yes 2X No
	with th	Director	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Country?
	death ms 23	Funeral		502 f Hispanic Origin? (Spe		U.S.A. 14. Race - American Indian,
9	or Iten		Amed Forces? 1 ★ Never Married 2 Married Amed Forces? 1 ★ Yes 2★ No	ıban, Mexican, Puerto I	Rican, etc.)	Black, White, etc.
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f show the Medical Evandrat must be inclined at	ed by	3 Wildowed 4 Divorced Year or Dates:			Specify: Black
<u>7</u>	nin 72 in "na Wedic	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occ (Give kind of work do	upation le during most of workir red)	ng 16	6b. Kind of Business/Industry
21	filed wilt Hygiene other the	Com	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		1	Her Home
and	ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) James Leo Knott	18. Mother's Name		,
ž	2 should be and Mental Is marked o	2		Mary Net		City or Town, State, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 Is marked other then "natural", or items 23c or 28a-1 show other traumatic event, Ite Medical Examinating must be retified at		, , , , , , , , , , , , , , , , , , , ,			rf, Maryland 20603
altimore,	of He of He If item) iš	20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place)	ace) April 1	2005 20	c. Location - City or Town, State
Ē	permit. Pages Department of a Important: If it eny injury or o		'4 □ Donation 5 □ Other (Specify) St. Catherine Cat	holic Chur	ch Mc	Conchie, Maryland
Ba	permit. Departr Importa eny inji		21. Signature of Funeral Service Licensed M00668 22. Name and Add Williams 4270	Funeral Ho	me, P.A.	
		7.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or negaritaliure. List only one cause on each line.	horne Rd.,	Indian I respiratory arrest	Approximate
	Firysician _I		Immediate Cause (Final disease or condition	The LUNG	2	Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	θ		7,0114
b	*	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	cuted hd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c			
Ď,	icate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
08/20	icate I physic	edical	d			
X	death certifi attending I	ician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
מ	0 0 2	sicia	in the past 12 months? 1	cy		Month Day Year
ŗ	that the	Physi	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	won in Sort I	Ola Didashaa	
cords,	requires that the een signed by th hould be detache	Q		iveniii raiti.	238. Did tobac	co use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Uhknown} \)
S S	a aw	ompleted			24a. Was an	24b. Were autopsy findings available
	The ate h page	Com			autopsy performed	prior to completion of cause of death?
V 152	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
	Phys r this ral di	5	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Ct 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Inju		e 5 🗆 Residence	9 6 □Other (Specify)
200	inding ath. r: Afte ie fune	atlor	1 Natural 5 Pending (Month, Day Year) Injury Wo	ork?]Yes 2 □No	ou. Describe now i	njury occurred
<u> </u>	or Atter ter de irecto n by tt	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	3f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
2	pitel cours at seral D		29a. Certifier Certifying Physicien: To the hest of my knowledge, death occurred at the t	4		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the total at the total at	me, date and place, ar opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	취급하는	Σ	29b. Signature and title of certifier 29c. Licen	se number	29d.	Date signed (Month, Day, Year)
	Vill Cor			17117		
3.0	Viii CO To	-		110/1	J	13115
B.	2 1 2 2		30 Name and address of picon who completed cause of death (Item 23a) (Type, Print)	KJ # 103	Fr. Wh.	131/05 Ludres un Dorge
Bl	子童 P		30. Name and address of picon who completed cause of death (Item 23a) (Type, Print) The April 1 and 1	11951 KJ #103	Fr. Was	131/55 hugges 2003 20144

	•	1 - For State Registrar	State of Marylar			nt of H <i>te of L</i>		and Me	ental I	lygier ۱ . _{Reg.} ۱	- W	05	128	90
		Decedent's Name (First, Middle, Last))						2. Date o			V	3. Time of I	Death
Physicia		John Kemp, Jr.							Month Apri		2005	Year	11:50	M G (
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of					of Death	,	
LAGIIIII		16800 Henderson R	oad		Н	ender	son				Car	oline		
Funeral		Social Security Number 6. Security Number		. last birthday)	If Unde	r 1 Year Days	If Under	24 Hrs.	8. Date o	Birth Day, Yea	ar)	9. Birtho	place (State or	r Foreign
Director		217-30-9374 ^{1X}	^{3M 2□F} 72	Yrs.	Worters	Duys	110010		Jan	7 193	3	Mary1	and	
p .		Usual Residence of Decedent 10a. State 10b. County	10c C	ity. Town or Lo	cation							1	0d. Inside Cit	v t imits
aryla shov	-											,	1 ☐ Yes	•
he M	Director	Maryland Caroline 10e. Street and Number		Hender		p Code				10a (Citizen of	What Cour	ntry?	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itams 23s or 28s-f show event, Ire Marical Examiting must be mailfied at	급		3		101.2	216	40				S.A.	***********	, .	
s 23	Funeral	16800 Henderson R	.O.a.a 12. Was Decedent Ever in l	IS 13	Was Dece			gin? (Spec	ify Yes o			ce - Americ	an Indian,	
ter de	Ĭ,	1 □ Never Married 2 🕅 Married	Armed Forces? 1 □Yes 2X No				n, Mexican	gin? (Spec n, Puerto R	lican, etc.)	Bla	ck, White,	etc.	
irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2X No	Specify:				Specif	y: Whi	te	
"naturai", or		15. Decedent's Edu	cation	16a. Dece	dent's Us	ual Occupa	ition	مانات مانات المانات		16b.	Kind of B	usiness/In	dustry	
Z nin Z	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	life.	DO NOT	ork done d use retired,	uring mos)	t of working	g					
d with	Completed	07		truck	dri	ver				ge	nera	l fri	eght	
be filed within 72 ho ital Hygiene. id other than "natur event, Ire Moulcal	Be	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Mic	ddle, Maid	en Sumar	ne)		
uld b Ments rked ric e	ToE	John Kemp, Sr.					Bert:	ie Hu	tson	Kemp)			
s ma	•	19a. Informant's Name/Relationship (Ty			•					-		State, Zip		
and 2 allth 27 i		Carolyn S. Kemp/		16800			n Roa					21640		
of He ritem		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, crea	natory or	ame of other place	θ)	Da	ate	20c.	Location	- City or To	wn, State	
Pag nent ant: i		`4 □Donation 5 □ Other (Specify)	Gı	reensbo	ro C	emete	ry	4/7/	05	Gr	eens	boro,	Mary1	and
permit. Pages 1 and 2 should be filed withir pepartment of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, Ir.e. Mones.		21. Signature of Funeral Service Licens	00			nd Addres			in F	unera	1 Hor	mo D	٨	
80 = 9		Men (f	leye								and	me 163	ġ ^A	
Physician /Medical		23a. Part1. Enter the disease, or complessock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	insor		-	4		respirato	ry arrest,			Approximate Interval Betw Onset and D	ween
within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and sompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.											
that the death certific the by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3[⊒Ectopic ; ⊒ Other (s	oregnancy specify)					1	ite of delive		'ear
res that igned b	by PI	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying	cause give	en in Part I			Did tobacc			ne cause of de	
w requir been si should	ted									1 1 1 42	2 200	3 1 100	ably 4 0	
ysician: The law ris certificate has be director, page 2 sh	Completed								2	Was an autopsy performed a		Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings a mpletion of ca 2 \(\text{No} \)	ivailable luse of
ı lcian : Th certificate rector, pag	Be	25. Was case referred to medical examiner?						of Death	(Check o	nly one)				
Physic this co	<u>P</u>	T Yes 21 No		ER/Outpatier			4 NC					ner (Specif	y)	
ding P. After t	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury Work			8d. Descr	ibe how in	jury occur	red		
or Attending Ph Itler death. Director: After th in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	M reet, facto		Yes 2		8f. Locati City or	on (Street Town, Sta	and Numi	ber or Rura	J Route Numb	ber.
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause and manner as stated.							tated. o the cause(s))					
withir To th	Me	29b. Signature and title of certifier	mo		2	9c. License	number			29d. [Date signe	d (Month,	Day, Year)	
) / DayKu	Wer MI)		D?	352	84		4	171	05	1601	
		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type,	Print)	1	- /		,					
		AWDREA ALL	owno 2	195	W	ishi	ngtu	m S1	t E	asti	mn	n0 2	1601	
Sta	te	31. Date filed (Month, Day, Year)	32, Registrar's Sign	nature	- 30		0	•					•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere 1

			1 - For State Registrar	State of Ma	arylar		artmen rtificat			and M		giene Reg. No.			2891
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of De Month	ath Day	/ Y	ear	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	AMINSK!			4h Cihi	T		4 D+b	March		County of	2005	12:35AM
	Examin	er	University of Mari		of Co	ater	Basi	2town, or	Location o	or Death		46.	NIB	Death	
	Funeral		5. Social Security Number 6. Sec	ex 7. Age	e (In yrs.	last birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bird (Month, Da	th v Year)	9.	Birthpla	ace (State or Foreign
	Director		205-40-0588	MM 2□F	53	Yrs.	MOINIS	Days	riours	191111.	Dec. 1	, 19	51	Piti	sburg, PA
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	d. Inside City Limits
	Many a-f sh	tor	OH Frank	lin	F	Reynold	sburg	5 -							1X☐Yes 2☐No
	or 28	Dire	10e. Street and Number				10f. Zip					-	izen of Wha	t Count	ry?
	sath w	eral	895 Ruskin Drive	12. Was Decedent B	Ever in 11	C 12.1	Mac Dagge	4306		ain? (Cno.	situ Vas ar Na		SA 14. Race -	Amaiaa	n Indian
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral Director	Never Married 2X Married Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 N N If Yes, Give Year or Dates:		'	f Yes, spec		Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)			White, e	tc.
5-0036	72 hou		15. Decedent's Ed (Specify only highest gra			16a. Deced	dent's Usua	I Occupa	ation during most	t of working	30	16b. Ki	nd of Busin	ess/Indi	ustry
2	ithin 7	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5	+)	life. I	DO NOT us	e retired)	O WOINE	'g				
2	illed w Hygier ther ti	Col	12 17. Father's Name (First, Middle, Last)	.,		Proj	ect M	lanag		r's Name	(First, Middle,		Const	ruct	ion
Maryland 2121	ed ital	To Be	James Kaminski	5 0:0		T and not		10:	Do	oroth	y Gran	tz			
Ma	and 2 sl ealth and n 27 is r		19a. Informant's Name/Relationship (7) Eileen Kaminski/			1	ng Address Ruski				Route Number	-		119, ZIP (4306	
Ē,	is 1 and if Health item 27 other tr		20a. Method of Disposition	-	20b. F	Place of Dispo cemetery, cren			-		ate		cation - Cit		
altimore,	Pages nent of ent: If it ury or o		14 Burial 2 ☐ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Specify			Marys				4/4/2	2005	Pit	tsbur	g, E	PA
Balt	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic 90028.		21. Signature of Funeral Service Licen	sөө.		1	6000 an	d Addres Anna	s of Facility	^y Robe s Roa	ert E.	Evan ie,	s Fun MD 2	era1 0715	Home
8760,	/Medical by social and find physician and ding physician and see as the burial-transit	dlcal Examiner	shock, or heart failure. List only is immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as a c. Due to (or as a d. d.	consequence consequence	uence of): uence of):	harc	hoi	n						interval Between Onset and Death
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rds, P	The law requires that the de te has been signed by the a rage 2 should be detached i	by	Part II. Other significant conditions co	ontributing to death bu	it not res	ulting in the ur	nderlying ca	ause give	en in Part I.		23e. Did to	-			cause of death?
Records,		Completed											24b. Werd prior deat	to com	sy findings available pletion of cause of
Vital	icien: sertific ector.	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
o	ng Phy fter this ineral d	lon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	v	ER/Outpatien 28b. Time of Injury		3c. Injury Work	" 4 □ Nui rat (? Yes 2 □ N	2	ne 5 Resid 8d. Describe h			Specify)	
Division	al or Attendi after death. I Director: A d in by the fu	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		iry - At he . (Specif	ome, farm, stre					8f. Location (S City or Tow			r Rural i	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phy (Chack only one) 2 Medical Exem	ysician: To the best of niner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred a restigation,	at the tim	ie, date and pinion, deat	d place, a	nd due to the d d at the time, d	cause(s) date and	and manne place, and	r as stat	ted. he cause(s)
	vithii To th	M	29b. Signature and title of certifier	7.			29c	License	number		-	29d. Date	e signed (M	fonth, Di	ay, Year)
,			· jamuel	w					144	14		3	130	105)
			30. Name and address of person who described the company of the co	nan 2	25	· Ors	Print)	S+	Ba	ltin	nore 1	117	220		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1	32. G gistra	ır's Signa	iture	Lough	,							

ysicia Medic	an al	1. Decedent's Name (First, Middle, Last Charles Wheatley	Lewis		ertificate of De		2. Date of Death Month	Day Ye	5 7.38 A
amin	eı .	4a. Fecility Name (If not institution, give Atlantic General H			4b. City, Town, or Lo			4c. County of D	ster
eral ector		5. Social Security Number 6. Se 220-26-8295 Usual Residence of Decedent	7. Age (In	71 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 06 / 06 / 1	9. (9.33)	Birthplace (State or Fo Country) MD
18 pa		10a. State 10b. County MD Worces	1	c. City, Town or L Berlin			-		10d. Inside City L 1 ☐ Yes 2
Lbe notif	Director	10e. Street and Number 9939 Main Stree			10f. Zip Code 21811		10	g. Citizen of What	Country?
event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 _ Yes _ 2 _ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spec Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)		merican Indian, /hite, etc. White
a Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)		(Giv	edent's Usual Occupation e kind of work done durin DO NOT use retired) nting	n ng most of workin	g	6b. Kind of Busine	
	To Be Co	17. Father's Name (First, Middle, Last) Daniel Lewis			18	. Mother's Name	(First, Middle, M		
i i		19a. Informant's Name/Relationship (7) Ruth Ann Lewis			ling Address (Street and Main Street				e, Zip Code)
eny injury or other once.		20a. Method of Disposition 1 urial 2 Cremation 3 4 Donation 5 Other (Specify. 21. Signature of Funeral Service Licens	Hemoval from State	Dale Cer	position (Name of sematory or other place) metery 22. Name and Address of the William S	04/04 of Facility The	1/2005 Burbag		lle, MD
	- 1				nter the mode of dying, s	30011 43 0410140 01	,	,	
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State of Maryland / Department of Health and Mental Hygiene

						Certificate of	f Death		Reg. No.		
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	/Med		Hugh Mall:	ick				Month March	27, 200	Year	6:50 am
>	Exami		4a. Facility Name (If not institution, give	e street and number,)		4b. City, Town, or	Location of Dea	th 4c. Coun	ty of Death	
			Manor Care-Poto					omac		Mont	tgomery
	_c Funeral		5. Social Security Number 6. S	Sex 7.Ag IDStM 2□F	ge (In yrs. last bir	Months Day			rth ay, Year)	9. Birthpla Countr	ace (State or Foreign
	Director		377-16-1540 Usual Residence of Decedent		92	Yrs.		Sept.	22, 191		th Dakota
	/land		10a. State 10b. County		10c. City, Tow	n or Location				10	Od. Inside City Limits
	Many	호	Maryland Montgo	omery		Chevy Chase					1 ☐ Yes 2 ☐ No
	r 28g	ie.	10e. Street and Number			10f. Zip Code			10g. Citizen of	f What County	m/2
	h wit	Funeral Director	8100 Connecticu	ıt Avenue,	#1414	208	15		reg. ozor, o.	USA	,,,
	deat	ner	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S	pecify Yes or No	o- 14. Ra	ace - America	ın Indian,
Baltimore, Maryland 21215-0020	be filed within 72 hours after death with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Mcdical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ဩtWidowed 4 ☐ Divorced	Armed Forces? 1 ☑Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐ No		o Rican, etc.)		ack, White, et <i>ify:</i> Whit	
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₫	it. Partme		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen.		Gate of	Heaven Cemet		2005	Silver	Spring	, Marylan
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1			29a. Certifier 1 Certifying Phys	iclan: To the best of	my knowledge, o	death occurred at the tin or investigation, in my o	ne, date and place, a	and due to the c	ause(s) and ma	nner as state	ed.
4	the f	Medical		and manner stat	ed.			ou at the time, d	ate and place, a	and due to the	e cause(s)
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-	3)		30. Name and address of person who co								
-			Kirti Vohra, M.D	. 7710 B	radley B	lvd., Bethe	esda, Mary	rland 20	817		
	Stat	е	31. Date filed (Month, Day, Year)	nns 32. Sistrar	rs Signature	Roselle					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Keith Romaine Mover 1142 A M /Medical -bril 2005 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Days Hours Yrs. Director 220-28-8189 May 10,1932 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location Items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director Md. 1 Yes 2 XNo Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17907 Bluebell Ct. 21740 Funerai U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Itel any injury or other traumatic event, Ite Manical Examinations. Black, White, etc. 1 Never Married 27 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 Research 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Vincent D. Moyer 2 Mammie E. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna E. Moyer (Wife) 17907 Bluebell Ct. Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 15, * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cemetery Smithsburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home WIS Smithsburg, Md. 21783 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atheroschosis Culcum /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760, physician Physician/Medicai the as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be been s 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 7 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No within 24 hours atter deatl To the Funeral Director: the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29c. License number person who completed cause of death (em 23a) (Type, Print) Da 11110 Year egistrar's Signature State 15 2015 Registrar

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IVISION	To the Hospital or Attending Physician: The I within 24 hours after death. To tha Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be	of Injury - At home, far	m. stree		_	28f. Location (St.	reet and Number or	Rural Route I	Number
5	afte Dire	ert	4 Homicide determined build	ing, etc. (Specity)		, , , , , , , , , , , , , , , , , , , ,		City or Town	, State)	710741 710016 7	<i>40111001</i> ,
	spita nours nera / fille		29a. Certifier 1 Certifying Physicien: To the	e best of my knowledge.	death of	occurred at the time.	date and place	and due to the ca	use(s) and manner	as stated	
	P Fu	edical	2 medical Examiner: On the c	asis of examination and	vor inve	stigation, in my opini	ion, death occu	rred at the time, da	ate and place, and o	lue to the caus	se(s)
	Nithir Somp	ž	29b. Signature and title of certifier			29c. License n	umber	29	9d. Date signed (Mo	nth, Day, Yea	ar)
			1 June 13	inte		DAG	0100		4-5-0		
_	1	+	30. Name and address of person who completed cau-	se of death (Item 22a) /	Type P		0.00	~	1 00	J	
	171		HENRY L. BURKE, MD,				T 7 T-	T 7 (1) 2	D 0000	_	
	Stat	е		legistrar's Signature	_	IGE AVE.	<u>LAP</u>	LATA, M	D 2064	0	
	Registra		ADD 1 5 2005	Marine H	10	edil					

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 1:30 PM 6, 2005 APRIL AUDREY KATHLEEN MARVASO /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 13655 BURNT STORE RD. <u>HUGHESVILLE</u> CHARLES 8. Date of Birth (Month, Day, Year)
JAN. 26, 1954
WASHINGTON, DC If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 20XF 51 Director 217-72-8046 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State or 28a-f show Examiner must be notified at 1 Yes 2 No HUGHESVILLE MARYLAND CHARLES Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a 13655 BURNT STORE ROAD 20637 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Market. 1 ☐ Yes 2 📉 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXXVo Baltimore, Maryland 21215-0036 Specify: Yes. Give WHITE þ 3 ☐ Widowed 4 ☒ Divorced Year or Dates: Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN_HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be REGINALD PHILLIP GILROY GLORIA ANN MAGNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DOUGLAS GILROY-BROTHER 17018 PRINCE FREDERICK RD., BENEDICT, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1√ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CHRIST CHURCH CEM. 4-12-05 WAYSIDE, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No ĕ 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, be Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes _2 ☐ 2 ☐ 2 ☐ 3 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 → Certification; To 27. Manner of Death 1. Naturat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Acoident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 70' 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

APR 1 5 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Apr 11. 2005 Miller 2:40pm [™] /Medical 4a. Fecility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** 12913 Growdenvale Drive Allegany Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month. Day, Year) Jul 24, 1923 Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2□ F Months Days Hours Min 215-16-4694 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Madical Examiner roust be notified at MD Allegany Cumberland Director 1 Xes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ō 21502 12913 Growdenvale Drive USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2 No IYes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No 3altimore, Maryland 21215-0036 Specify À Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "1 any injury or other treumatic avent Elementary/Secondary (0·12) College (1-4or 5+) Associate Goddard Space Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Miller Mazie (Cosner) Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland MD 21502 Maxine Miller wife 12913 Growdenvale Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, PA 4/13/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ekanoma months /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed 2/2 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 24万No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 THomicide within 24 hours a To the Funeral D 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Mehanna M.D. 902 Seton Drive Cumberland MD 21502 32. Registrar's Signature State APR 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 11:30A M Jean McIntire Apri 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 0akland Garrett Garrett County Memorial Hospital 8. Date of Birth (Month, Day, Yeer) Oct. 13, 1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 220-10-1157 85 1919 Maryland Director Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28e-f show 1 ☑Yes 2 ☐ No Directo Garrett 0akland 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 729 E. Oak St. 21550 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status per it. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Immortant: If item 27 is marked other than "naturel", or Item an injury or other treumatic event, it a Medical Examin 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: δ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Store 12 Sales Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stephen Sanders Shaffer Jane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 555 S. Third St., Oakland, Maryland 21550 Paul W. Hoye, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oakland Cemetery 4/8/2005 Oakland, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral/Service/Licarisee 32 S. Second St., Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stroke Immediate /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Disease Years Sequentially list conditions, in my learning to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2₽No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s 1 Yes 2 No 1□ Yes 2□No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: <u>L</u> 1 ☐ Yes 2 ☐ 1√0 1 Diffipationt 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 - Homicide within 24 hours after To the Funeral Dire 1 Destifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of celtifie 29c License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2005 Registrar APR -

		4	irtment of Health and Mental Hy	
Physici /Medi Examin	ċal.	1. Decedent's Name (First, Middle, Last) Brenda Lee Majors 4a. Fecility Name (If not institution, give street and number)	2. Date of De Month Market Land Color of Death	ath Day Year 3. Time of Death
Funeral Director	, , , ,	Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214–52–1199 1□ M 2 F 47 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bir Months Days Hours Min. (Month, Da	th 9. Birthplace (State or Foreign
Ne Maryland 8e-f show	Director	Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc MD Dorchester	Hurlock	10d. Inside City Limits 1 ☐ Yes 2 ☑No
23e or 2	ral Dire	10e. Street and Number 6638 Pine Top Road	10f. Zip Code 21643	10g. Citizen of What Country? USA
11215-0036 within 72 hours after death with the Maryland ene. then "netural; or Items 23e or 28e-f show the Madical Examiner must be muilified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	/as Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 No Specify:	14. Race - American Indian, Btack, White, etc. Specify: white
215-000 thin 72 hours e. "netural",	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation rind of work done during most of working O NOT use retired)	16b. Kind of Business/Industry
Maryland 21215-0036 d 2 should be filed within 72 hours att th and Mental Hyglene. 77 Is marked other then "netural", or treumetic event, the Madical Exami	Be Con	12 2 17. Father's Name (First, Middle, Last)	engineer 18. Mother's Name (First, Middle,	electronics mfy. Maiden Surmarne)
should to marked metic e	To I	Kenneth Hubert Majors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Dorothy Bou	
re, Ma 1 and 2 : Health ar tem 27 is		Janice Hoffman p.r. P. O	Box 877, Hurlock, MD	21643 20c. Location - City or Town, State
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filled within 72 ho Department of Health and Menial Hyglene. Important: If item 27 is marked other then "neturn any injury or other treumetic event, the Madical ance.		1 Magazia 2 □ Cremation 3 □ Removal from State cemetery, crem. 1 Donation 5 □ Other (Specify) 1 Section 1 Section 1 Section 2 Cemetery, crem. 1 Section 2 □ Cremation 3 □ Removal from State Cemetery, crem.	atory or other place)	East New Market, MD
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	O Locust St., Cambridge,	
Box 68760, and certificate be executed attending physician and for use as the burial-transit	edical Examiner	timmediate Cause (Final disease or condition resulting in death) Concern and the conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a	non small cell)	Onset and Death Him in
vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certificat death. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as th	by Physician/Med		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
cords, P		Part II. Other significent conditions contributing to death but not resulting in the unc	derlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 □Unknown
Vital Records, sicien: The law requires to certificate has been signe rector, page 2 should be contracted.	e Completed	25. Was case referred to medical		prior to completion of cause of death? 1 Yes 2 No
Division of Vita or Attending Physicien: after death. Director: After this certific, in by the funeral director.	To B	examiner? 1 Yes 2 Yes 2 Yes 4 4 4 4 4 4 4 4 4	26. Place of Death (Check only of 3 DOA Other: 4 Nursing Home 5 Resid 28c. Injury at Work? M 1 Yes 2 No	
Divisio	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office 28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)
Divisic To the Hospitel or Attency within 24 hours after death To the Funerel Director: completely filled in by the:	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of and manner stated.	occurred at the time, date and place, and due to the costigation, in my opinion, death occurred at the time, o	ause(s) and manner as stated. late and place, and due to the cause(s)
To ti withi To ti	×	29b. Signature and title a certifier		29d. Date signed (Month, Day, Year)
		30. Name and address of person who empleted cause of death (Item 23a) (Type, Pr	509 IDLEWILD ALE	EASTON 21601
Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 2005 32. Registrar's Signature	ack t	

		•	For State Registrar		State of N	1arylan	•	artmen rtificate			and M		giene	200	5 1290
	Physicia /Medic		1. Decedent's Name Mary	Jean	· 	Murph	ny					2. Date of De Month April	Day	Year 200	5 5:30A M
	Examin Funeral	er	4a. Facility Name (If Charles 5. Social Security Nu	County mber 6. Se	Nursin	g Reh	nab last birthday)	1	a P1	ata If Under:		8. Date of Bir (Month, Da	th	Cha 9. Bi	rles rthplace (State or Foreign
	Director		220-30-7 Usual Residence of I	302	□M 2ĂF	83	Yrs.		Days	riours		June			Maryland 10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f show rmss Lte rectified at	Director	MD 10e. Street and Num	Charl	es	Wł	nite	Plai					10g. Citizer	n of What C	1 □ Yes 2 No
	death with ms 23a or	Funerai Di	9319 C1	ifford	12. Was Deceder	nt Ever in U.	S. 13.		0695 dent of Hi		gin? (Sp	ecify Yes or No Rican, etc.)			erican Indian,
	in 72 hours after death with the Marylan "natural", or items 23a or 28a-f show ledical Examiner must be millited at	by	1 ☐ Never Marrie	_	Armed Forces 1 ☐ Yes 2 (If Yes, Give Year or Dates] No		If Yes, spec		n, Mexican Specify:	i, Puerto	Hican, etc.)		Black, Wh	White
7-61217	with ane.	Completed		15. Decedent's Edu y only highest grad dary (0-12)		r 5+)	(Give life.	dent's Usua kind of wo DO NOT us US IN (rk done d se retired	turina most		ing		of Busines:	s/Industry Store
ylandz	should be filed and Mental Hygid marked other umatic evant, the	To Be C	17. Father's Name (Francis	Claude						Anna	a Ca	First, Middle theri	ne Wi	nkle	
Маг	tra tra		19a. Informant's Nar Sandra	Pitrell:			P.0	. Box	x 41	.2 Be	e1 A	1 ton, 1	MD 2	0611	
Baltimore	t. Page ntment o rtant: if njury or			Cremation 3 IF 5 Other (Specify))	.0	lace of Disponentery, creations.	atius	s Ce	em. 4	4/4/	05 I	Port	Toba	r Town, State
e n	Deparii Impo any ir snce.		23a. Part1. Enter th	Or s	160	CHARLES .	Do not en	AREHA P.O.	ART - BOX	ECHO	OLS 7 I.A	FUNERA PLATA	AL HO	ME, P 206	46 Approximate
	Physician /Medical Examiner		shock, or head Immediate Cause (F disease or condition resulting in death)	italiure. List only o Final	a Due to (or a	ne.	nce of):	س	Fa	ulu	4	7 ,			Interval Between Onset and Death
9/60,	certificate be executed rding physician and use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
O. Box 6	eath certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	ldeath 3[⊒Ectopic pr ⊒ Other (sp					230	d. Date of de Month	alivery Day Year
ecords, P	w requires that the dibeen signed by the should be detached	þ	Part II Other significant	ant conditions co	entributing to death	but no resu	lting in the u	inderlying o	ause give	en in Part I.			obacco use Yes 2 ☐ N		to the cause of death? Probably 4 Unknown
r	The far ate has page 2	Completed	Jay	-9-(Linkel	is_(hill	itu	1			24a. Was auto perfo 1 \(\text{Yes}		prior to death?	autopsy findings available completion of cause of
VII	Physician: this certific ral director,	o Be	25. Was case referred examiner?	_	Hospital: 1 ☐ Inpa	itient 2 🗆	ER/Outpatie	nt 3 DC	Othe			h <i>(Check only d</i> me 5 ☐ Resi		Other (Sp	ecify)
DIVISION OF	ding After fune	ertification; T	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not be	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of Injury	of 2	8c. Injun Work 1 🗀 '		7	28d. Describe	how injury o	ccurred	
Ž O	To the Hospital or Attan within 24 hours after deatl To the Funeral Diractor: completely filled in by the	O	3 Suicide 4 Homicide	determined	building,	etc. (Specif)	·)					City or To	wn, State)		Rural Route Number,
	To the Hospitai within 24 hours a To the Funerai I completely filled	edicai		1 ☐ Certifying Phy 2 ☐ Medical Exam		of examina		vestigation	, in my of	pinion, dea			date and pl	ace, and du	ue to the cause(s)
	To t Com	M	29b. Signature and t	itle of certifier	- Bn	de	dis	290	-	o number	00	9		signed (Mor	nth, Day, Year)
9	D 5		30. Name and addre	ss of person who called the same of the sa			23a) (Type,					20646			
Í	Sta		31. Date filed (Mont	APR 0 2	32. Reg	trar's Signa	ture	hart							

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			giene Reg. No.	05	120	002
1	Physicia		1. Decedent's Name (First, Middle Robert Roy Mas					2. Date of De. Month March	ath Day 29, 200	Year 5	3. Time of 9:15	Death A M
	/Medic		4a. Fecility Name (If not institution)	4b. City, Town, o	or Location of Dea		4c. County			
			12631 Hillmeade			Bowie	T Killawa 24 Us		Princ			
	Funeral Director		5. Social Security Number 218-66-6589 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birthda) 50 Yrs.	Months Days			th 1954	Count	ace (State o try) ington	
yland	Now.		10a. State 10b. County		10c. City, Town or	ocation				10	0d. Inside Ci	•
ы Мал	8a-1 s	Director	Maryland Prince	Georges	Bowie	10f. Zip Code			10g. Citizen of	Mh at Cour	M∏ Yes	2 🗌 No
with t	a or 2	Dir	10e. Street and Number	o Ctation D		20720			USA	What Cour	uy:	
death	na 23	Funeral	12631 Hillmead	12. Was Decedent	Ever in U.S. 13	. Was Decedent of I	Hispanic Origin? (Specify Yes or No	- 14. Ra	ce - America		
1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or Itama 23a or 28a-f show Important: If Itam 27 is marked other than "naturel", or Itama 23a or 28a-f show any injury or othar traumatic event, Itam Medical Examinat must be notified at 20.0s.	by Fun	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced			If Yes, specify Cub 1 ☐ Yes 2X No		rto Hican, etc.)	Specia			
5-00 72 hou	natura Ical E	ted l	15. Deceden: (Specify only highes	's Education	16a. Dec	edent's Usual Occu re kind of work done		orkina	16b. Kind of B	White Business/Ind		
21.5 /ithin 7	han "r	Completed	Elementary/Secondary (0-12)	College (1-4or	[ife	DO NOT use retire Manager y Communi	ed)		Desire	C		
E S	Hygie ther t	CO	17. Father's Name (First, Middle,	Last)	Safet	y Communi		ame (First, Middle,	Prince Maiden Sumai		es cou	шсу
Maryland 21215-0036	Nental rkad o tic eve	To Be	Leroy Walter Ma				Jean Wa	rthen Co	rbitt			
lary 2 shou	and h		19a. Informant's Name/Relations			iling Address (Stree						
6, 7	lealth am 27 thar tr		Catherine Victo	ria Mason/	20h Place of Dis	1 Hillmea		on Drive	Bowie,			
nor	nt of the		1 ∑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery, cr Mar	ematory or other pla yland Cemetery	nce)	0//2005				
Baltimore,	ortan injury		21. Signature of Funeral Service		veterans	Cemetery 22. Name and Addr	ess of Facility R	04/2005 obert E.				1e
Ö	Depar Impo any ir		> Kelly		4	16000 Ann	apolis R	oad Bowi	e, MD 2	0715		
E	Medical xaminer transit the purial-transit	cal Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Malign Due to (or a b. Due to (or a c.	ant Melanc s a consequence of): s a consequence of): s a consequence of):	ma					Interval Bet Onset and I	
Box 6	e attending pod for use as	Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	B Ectopic pregnanc	Бу			ate of delive		Year
	වූ ල්	by	Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause g	iven in Part I.		tobacco use cor Yes 2 ☐ No	atribute to th		death? Unknown
I Rec	ate has b	e Completed	25. Was case referred to medica				ne Place of D	24a. Was auto perfo 1 Yes	psy ormed? 2 X No	Were autop prior to con death? 1 Yes	psy findings npletion of c	available cause of
	is certitic director,	0 8	examiner? 1 Yes 2 No	Hoenital:	tient 2 ER/Outpat	ent 3 DOA O		Home ≸ ∏ Resi		her (Specify	()	
	After fune	tion: T	27. Manner of Death 1 X Natural 5 Pendir 2 Accident investi		jury 28b. Time lnjury	of 28c. Inju			how injury occu		,	
5	atter deatl	Certification:	3 Suicide 6 Could 4 Homicide determ	sined 289. Place of II	njury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rura	l Route Num	nber,
]		ledical C	29a. Certifier (Check only one) 1X Certifyii 2 Medical	ng Physicien: To the bes Examiner: On the basis and manner s	of examination and/or	ath occurred at the tinvestigation, in my	time, date and place opinion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place	anner as st , and due to	ated. the cause(s	5)
To the	withir To th comp	Me	29b. Signature and title of certifie	or .	0	29c. Licen	ise number		29d. Date sign	ed (Month,	Day, Year)	
)			Maco	FRILLE	5		23743		3/29/	05		-
			30. Name and address of person Martin Weltz,		death (Item 23a) (Typ eenway Cen		Greenhe	1t. MD 20	0770			
	St	ate	31. Date filed (Month, Day, Year,	32. egis	trar's Signature	1 4.	or combe	_ tu 2	<u> </u>			
	Regist	rar	MAR 3	2005	we do to	2046						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

٨	mended		For State Registrar	item #20c &	State of N									6 5	12903
A				ne (First, Middle, Last)				/				2. Date of De	ath	Year	3. Time of Death
	Physici /Medic		Lore	e Hz	NZ	111	NG	نه٥٢				4		005	12:05 PM
1	Examin		4a. Facility Name (If not institution, give s	treet and numbe	or)	- 10	4b. City,	Town, or	Location	of Death	•		nty of Deeth	4
			11/1-	Number 6. Sex	ord 1	HOSP	last birthdey	at If Under	r 1 Year	If Under	24 Hrs	8. Date of Bi			place (State or Foreign
	Funeral Director		5. Social Security 1		M 2 3 F		60 Yrs.	Months		Hours	Min.	(Month, Da	2/1944	Cou	hington, DC
			Usuel Residence of							1		00,1			
	irylan ihow	_	MD	Worcest	or	_	ity, Town or I								10d. Inside City Limits 1X Yes 2 □ No
	Ba-f.	ecto			<u></u>		Cean		0.1				40-0%	(145	
	72 hours after death with the Maryland natural', or Neme 23a or 28a-f show Jical Executors	Funeral Director	10e. Street and Nu		Bood !	Buildi	ng A2	10f. Zip	2184	12			10g. Citizen o		antry r
	eath 18 23	erai	11. Marital Status	ard Taylor	2. Was Decede			. Was Dece			igin? (Spe	ecify Yes or No		ace - Amer	ican Indian,
10	r Hen	ᆵ		ried 2X Married	Armed Force 1 ☐ Yes 2 1	s?						ecify Yes or No Rican, etc.)		lack, White	
5-0036	raf', o	by	3 ☐ Widowed	4 ☐ Divorced	If Yes, Give Year or Date:	s:		1 🗌 Yes	2 X No	Specify:			Spec	cify: VV	hite
5-0	n 72 hours natural',	Completed	(Spe	15. Decedent's Educ cify only highest grade			(Giv	edent's Usu e kind of wo	ork done o	durina mos	t of worki	ing	16b. Kind of	Business/Ir	ndustry
121		mp	Elementary/Sec	ondary (0-12)	College (1-40	or 5+)		nager	ise retired	1)			Rest	auran	\ +
d 21	filed v Hygie ther			(First, Middle, Last)			IVICI	nagei		18. Mothe	er's Name	e (First, Middle	, Maiden Sum		
an	should be filed within the Mental Hygiene. marked other than matte event, the Mental than the	To Be	Larry	_					ļ	He	len	Botler			
Maryland	W = = 3	-	19a. Informant's N	lame/Relationship (Typ	oe, Print)		19b. Mai	ling Address	s (Street a	and Numbe	er or Rura	l Route Numb	er City or Tow	n, State, Zi	ip Code) 21842
×	1 and 2 s Health ar Iem 27 is		James Na	arrington	(husban	d)	105	Edwar	d Ta	aylor	Roa	d Dun	11 20 7	0ce	an City MD
ore,	es 1 au of Hea f Item r othe		20a. Method of Dis	sposition Cremation 3 □Re	amoval from Sta		Place of Disp cemetery, cr	position (Na ematory or o	me of other plac	:e)	C	Date	20c. Location Frankf	n - City or T	own, State
altimore	Page ment: It ant: It			5 ☐ Other (Specify)	ellioval ilolli Sta	Ca							-Frnak	ford,	· DE
Balt	permit. Pages Department of Important: If I any injury or once.		21. Signature of F	uneral Service License	7	A		22. Name a	nd Addres	ss of Facili	y Bur	bage F	uneral	Home	
ш	70 E 3 9	3.44	Taco	Julina]	· Das	feet	1						lin, MD	2181	
Ye.		8	/ shock, or he	the disease, or complicant failure. List only on	e cause on each	line.	Do not e					or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	Ĥ	Immediate Cause disease or conditi resulting in death)	on	VENT	trico	10	2/	ch	7 h.	212				4 days
,et	Examiner		,		Due to (or	as a conse	quence of):	(/	1120		pothy			
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	cate be executed oblysician and the burial-transit	Examiner	cause. Enter Und Cause (Disease o that initiated event	eriying r injury ts											
o,	an an rial-tr		resulting in death)	Last	Due to (or a	as a conse	quence of):								
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39 >	leath certificate be exe attending physician ar I for use as the burial-t	Physician/Medical	IF FEMALE:												
Вох	death ce e attend ed for us	lan/	23b. Was deceded	nt pregnant	3c. If yes, outcom	2 Fet	al death 3	□Ectopic p						Date of deliv Month	very Day Year
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<u>a</u>	es that the de igned by the be detached	/Ph	Part II. Other sign	ificant conditions con	tributing to death	but not re	sulting in the	underlying	cause give	en in Part I		23e. Did	tobacco use co	ontribute to	the cause of death?
Records,	requires een sign nould be	d by										1 🗆	Yes 2□No	3 Pro	bably 4 🗀 Unknown
S	N 02 02	Completed										24a. Was	an 24t	o. Were aut	opsy findings available
Re	0 2 0	шс											psy ormed? 2 4 No	death?	ompletion of cause of 2□ No
Vital	ician: Th certificate rector, pag	O	25. Was case refe	erred to medical						26. Place	of Death	1 Yes		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
<u>></u>		To B	examiner?	No H	ospital:	atient 2] ER/Outpati	ent 3 D	OA Oth	05			idence 6 🗆 C	ther (Speci	ify)
J of			27. Mann of Dea	ath 5 Pending	28a. Date of II	njury Day Yeer)	28b. Time Injury	of	28c. Injun Worl	y at k?		28d. Describe	how injury occ	urred	
iö	Attending r death. ector: After by the fune	atic	2 Accident	investigation			,	М		Yes 2 🗌	No				
Division	r Atter de irecte	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of building,	Injury - At it etc. (Spec	nome, farm, s	street, factor	ry, office		1		'Street and Nui wn, State)	mber or Rui	ral Route Number,
Q	urs af	Ö			1										
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	1 ☐ Certifying Phys 2 ☐ Medical Examin	ner: On the basis and manner	of examin	ation and/or	ath occurred investigation	n, in my o	ne, date ar pinion, dea	nd place, a th occurr	and due to the ed at the time,	date and place	manner as : e, and due i	stated. to the cause(s)
	ithin (ithin or the comple	Med	29b. Signature an	d title of certifier	and manner	Stateu.				e number			29d. Date sign	ned (Month	, Dey, Year)
	F 3 F 8		11	10-11		01.			HU	142	83	•	4/1	1/0	5
•	_		30. Name and add	dress of person who co	mpleted cause of	death (In	m 23a) (Type	e, Print)	1/ /	101	- 4,00	Drive		1/0	
C	7 2		Robo		11 K. 2)	97	33 F	4/21	Thw.	14	Drive	·	Berl.	IN, MD
	Sta		31. Date filed (Mo	APR 0 5 2	105 32. P	strar's Sign	ature	1						100	
/	Regist	ar		THE TOTAL CO	UUU I	DIE V	N. A	GY STA	A. C. C. C. C. C. C. C. C. C. C. C. C. C.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Edward 2, Α. Newcomb April 2005 1415 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hospital Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. Mar. 30, Year 38 If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 MM 2 □ F Yrs. 67 Marvland Director 218-34-8756 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Exercitive frost the rediffed at Talbot Easton MD 1 ☐ Yes 2√☐xNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 United States 6110 Manadier Road permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Items 23a any injury or other traumatic access. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □X/ss 2 □ No
If Yes, Give
Year or Dates: 162-68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Grain 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Sedonia John Newcomb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 313 Cherry St. 16, Easton, MD Travis E. Newcomb/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cem. 4/8/2005 Hurlock, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 216 N. Main St. Federalsburg 21. Signature of Funeral Service Licensee once Framptom Funeral Home, 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) e lung concer Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 √Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 Yes 1 ☐ Yes 2 ☐ No 2 12 No Hospital or Attending Physician: 24 hours after death, Funeral Director: After this certifica director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dev. Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 David Smith 29466 Pintail Dr. Easton, Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

7 2005

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Fur	xamin neral		HARBOR HOSE 5. Social Security Number 6. S	PITAL CEN		st birthday)		TIM	cation of Death	8. Date of Bir	th 1	Balt	imor	lace (State	or Foreign
pu ,	ector		Usual Residence of Decedent 10a. State 10b. County			Yrs. Town or Lo				Januar	у 3.		Nige	ría Od. Inside C	City Limits
death with the Maryland ms 23a or 28e-f show	be notified	Funeral Director	MD Baltimo:		Dai	LIMOI	10f. Zip C		·			itizen of W			s 2 No
0036 hours after death ural', or items 23	Evaminer mus	by	2400 Marbourne A 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:					anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)			- Americ k, White,		
vithin 72 halene.	he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	-)	(Give life.	dent's Usual kind of work DO NOT use Lstere	done duri retired)	ing most of work	king		Kind of Bus		lustry	
Yland 2 rould be filed I Mental Hyg	atic event,	To Be C	17. Father's Name (First, Middle, Last, Jonathan E. Osil	kominu				18	. Mother's Nam Eunice	e (First, Middle, O. Odur	Maidei nubi		e)		
and 2 sh and mark	her treum		19a. Informant's Name/Relationship (Donna Owolabi/Dat			18305	Bubb	ling	Number or Rui Spring	Terrace	er, City Bo	or Town, S yds	State, Zip Mary	Code) land	2084
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28e-1 show	eny injury or otl QDCe.		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Dopation 3 ☐ Other (Specification) 21. Signal recolf funeral Service I continued to the serv		cen	ily P	. Name and	ar place) Address o	5/13 of Facility	/2005 . B. Jer	San nk i n	s Fur	liada neral	n Ni.	2
Physic /Med	lical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	IRAC		er the mode of	of dying, s	CI ROAG		rrest,	Mary		Approximat Interval Bet Onset and i	ite tween Death
58760, icate be executed XIII physician and XIII		CT.	Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPET Due to (or as a	conseque	nce or):	V								
Box 6 sath certif	ris .	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal de	eath 3	Ectopic preg Other (speci					23d. Date Mont		,	Year
Cords, P. wrequires that been signed by	e p	ď,	Part II. Other significant conditions c	ontributing to death but	not resulti	ng in the un	derlying caus	se given ir	Part I.		obacco i			cause of d	
	page 2	Completed								24a. Was a autop perfor 1 🗆 Yes	SV	pri de	or to com ath?	sy findings a pletion of ca	available ause of
on of ling Phys After this	al direct	LOB	25. Was case referred to medical examiner? 1	Hospital: 1 Empatient 28a. Date of Injury (Month, Day)		VOutpatient 3b. Time of Injury		Other: Injury at Work?	4 🗌 Nursing Ho	me 5 Resid	lence				
DIVISION tel or Attending s after death. el Director: Afte	ad in by the	Certification:	3 Suicide 6 Could not be determined		r - At home (Specify)	e, farm, stre	et, factory, o			28f. Location (S City or Tow	itreet an n, State	d Number	or Rural	Route Numi	ber,
To the Hospitel or within 24 hours after To the Funerel Direction	pletely fills		29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of o niner: On the basis of e and manner state	xamınatior	edge, death n and/or inv	occurred at t estigation, in	he time, c my opinic	late and place, on, death occurr	and due to the c ed at the time, c	ause(s)	and manr place, an	ner as sta d due to t	ted. he cause(s)	;)
To t To t	соп		29b. Signature and title of certifier **Lambour 5	refr. PC			R	cense nu	mber			te signed (-	ay, Year) 200	5
	0.		30. Name and address of person who described SHAFF 1 31. Date filed (Month, Day, Year)	, 3001 SOUT	14 14	Anci		TRE	EET	BALTN	10 R	18 h	CAP	2122	25
Re	Stat gistra	~	APR 0 4 2005	32. Registrar's											

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Charles	Lyne1	Phillips	
05-2291			
AKG		1 - State	

49. 	I.		1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>		Mental H	ygiene Reg. No		12906
	Physici	an	Decedent's Name (First, Middle, L					2. Date of D	eath Da	y Year	3. Time of Death
	/Media	cal	Charles Lynel					April	1,	2005	1:25 A M
	Examin	er	4a. Facility Name (If not institution, gr 500 Calvert Stre			4b. City, Town, or		ith		. County of Death	
	Funeral	_			e (In yrs. last birthday)	Chesterto	DWN If Under 24 Hr	S. 8 Date of B		Kent	plana (State or Foreign
	Director		212-17-3054	Sex 7. Ag 10. M 2 □ F	32 Yrs.	Months Days	Hours Mir	s. 8. Date of B	ay, Year 19	72 Coun	place (State or Foreign htry) MD
	put *		Usual Residence of Decedent 10a. State 10b. County		100 Cit. T						
	sho	'n			10c. City, Town or Lo					1	Od. Inside City Limits
	the A	Director	MD Kent		Worton	10f. Zip Code			10- 0"	(1111 0	1 ☐ Yes ¾☐ No
	death with the Maryland ima 23a or 28e-f show firmst be notified at	0	25493 Pine Rd			21678			rog. Ca	izen of What Coun	itry ?
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Specify Yes or N	0-	14. Race - Americ	an Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked othar than "natural", or Itama 23a or 28e-1 show any injury or othar traumetic evant. The Medical Exartifical Exartifical to collar traumetic evant.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No I	f Yes, specify Cubar 1 □ Yes 2 No	Specify:	rto Rican, etc.)		Black, White, Specify: Bla	
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12	within ane. than	ldmi	Elementary/Secondary (0-12) 12th	College (1-4or 5	9	E					
р 5	filed Hygid Sthar ant, I	ပိ	17. Father's Name (First, Middle, Las	"	Carp	enter	18. Mother's Na	me (First, Middle			corp.
an	lid be lental rked o	To Be	Sheldon Phil	lips				a Hick	, maraon	Sumame)	
ary	2 should and Men is marks sumetic		19a. Informant's Name/Relationship		19b. Mailin	g Address (Street a			per, City o	r Town, State, Zip	Code)
	and 2 ealth n 27 i		Sheldon Philli	ps-Father		3 Pine I	Rd Wor	ton, MI	21	678	
ore	Pages 1 nent of Ho nnt: If itan nry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from State		natory or other place)	Date		ocation - City or To	
Baltimore,	t. Partmen rtent: njury		` 4 I Ponation 5 ☐ Other (Speci	fy)	Union U					ton, Ma	
Bal	permit. Departn Importe any injt		21. Signature of Funeral Service Lice	allery	100024 S	Name and Address	321 W	St Anna	ipol:	ley Fun is, MD	eral 21401
			23a Part1. Enter the disease, or con hock, or heart failure. List only	plications that daysed one cause on each lin	the death. Do not ente	er the mode of dying	, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
E	Pnysician /Medical	: 6	Immediate Cause (Final disease or condition resulting in death)	a. GWSHO	A WOUNT	10 70	THE	HE	AC)	Onset and Death
	Examiner		1	Due to (or as	a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury	b. Due to (or as a	a consequence of):				_		
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	6							
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68760,	tificate be executed g physician and as the burial-transit	edical		_ d.							
			IF FEMALE:	23c If wee outcome	of prognancy				-		
Вох	atten I for u	Iclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			2	3d. Date of deliver? Month	ry Day Year
О	the d ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown	5 deg.(i) 5 d	Other (specify)					
ις Τ	The law requires that the death cer tte has been signed by the attendir page 2 should be detached for use	by Phys	Part II. Other significant conditions	contributing to death bu	it not resulting in the un	derlying cause given	in Part I.	23e. Did 1	obacco u	se contribute to the	e cause of death?
Records,	w require been sig should b							1 🗆	Yes 2	□No 3 □ Proba	ably 4 □Unknown
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Vital	E 5	Be	25. Was case referred to medical examiner?					ath (Check only o			
0	hys his hidii	2	1 XYes 2 No 27. Manner of Death	Hospital: 1 Inpatier			4 Linuising F	lome 5 ☐ Resi	dence 6	Other (Specify)	at scene
	ding h. After funer	ton	1 □Natural 5 □ Pending	28a. Date of Injun (Month, Day	Year) Injury	28c. Injury a Work?	es 2. XINo	28d. Describe			4.70
DIVISION	il or Attending after death. Diractor: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	11103	rv - At home, farm, stre		5 2 2 1 VO			Number or Rural	
_	ator safter	Certification;	4 Momicide determined	building, etc.	ry - At home, farm, stre . (Specify)	or, radiory, ornod		City or To	vn, State)		ERNUN, YD
	ia Hospital or Af		29a. Certifier 1 ☐ Certifying Ph (Check only 2 [X] Medical Exam	vsician: To the best of	f my knowledge, death	occurred at the time	, date and place	and due to the	Calleo(e)	and manner as ste	uto d
	<u> </u>	ledical	one)	and manner stat	examination and/or inve	estigation, in my opir	nion, death occu	irred at the time,	date and	place, and due to t	he cause(s)
	To To	Σ	29b. Signature and title of certifier	~		29c. License r				signed (Month, D	
			- mors			OCM			aprı.	L 1, 2005	
			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, P		n Street	t Ro1+∔	movo	, Marylar	ad 21201
100	Stat	e	31. Date filed (Month, Day, Year)	32. Regian	r's Signature		i pries	r Dalil	THOTE	, maryiar	IU ZIZUI
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State of Maryland / Department of Health and Mental Hygiene State Registra MEND#31see#32BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea **Physician** 1.00 PM LOGAN A. PATTERSON 2005 03 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death **Examiner** UNIV. OF MARYLAND MEDICAL BALTIMORE MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months 1X M 2□ F Maryland unavailable March 15, 2005 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show Examiner must be notified at 1X Yes 2 □ No Directo Washington $D_{\bullet}C_{\bullet}$ N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 1266 Morse Street, N.E. #305 20002 United States Items 23a by Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "naturel", or Itel minuty or other treumatic event. The Medical Examinations. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: African American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alonzo Patterson Tina Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1266 Morse St. N.E. #305, Washington, D.C. Alonzo Patterson (father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/6/05 Chesapeake Crematory Beltsville, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Sign yury of Funeral Service Licensee 7400 Georgia Ave. N.W., Washington, D.C. 20012 Hugen were 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BILIRUBIN Physician ENCEPHALO PATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEVERE INTRA VENTRICULAR HEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit DISSEMINATED INTRAVASCULAR COAGULATION that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2□ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 10 1 🗌 Yes 2 **□** No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hadhan.S P18664 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GREENE STREET, BALTIMORE, MD 21201 MD MADHAVI SANGEM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 01 Registrar 03

State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Day Year 30 2005 /Medical March 3:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-05-3580 1 M 2 F 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medicul Evantiner must be notified at 1 ☐ Yes 2 No Director Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a or den 21830 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marned 9 1 ☐ Yes 2 No Specity. þ Specify: Black 3 ₩Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other transmets. Elementary/Secondary (0-12) College (1-4or 5+) Worker 11th GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) oulbourn 9/12Abeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Hazel Jones 23881 HEAD OF Creek Rd Quantico Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John Wesley Cemetery 6-05 21. Signature of Proeral Service Licensee 22. Name and Address of Facility 601 Bemie Smith Funeral Home 917 WEST ISAbella St. Solis, MD 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart rejlure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEAHYTHAVA /Medical Due to (or as a consequence of): Examiner NOITSTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit physician a s the burial-Due to (or as a consequence of) P.O. Box 68760, Be Completed by Physiclan/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months. Month Year 4☐Pregnant at time of death Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of eause of death?

1 ☐ Yes 2 ☐ No ETES 24a. Was an autopsy performe certificate CRAC 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 1 Yes Other: 4 Mursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann-uni Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attanding 5 Pending investigation 1 Watural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) APR 0 4 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖺 🕦 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** March 30, 2005 Ambrose R. Phillips, Jr. 6:45 A. M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Center Prince Georges Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Mar. 10, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**2** M 2 □ F Months 254-56-4118 65 Mar. Director Georgia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow iral, or Items 23a or 28a-f ahov Exemple: must be restilled at 1 X Yes 2 □ No Directo Md. Prince Georges Bowie the 10e. Street and Number 10f. Zip Code 10g. Cilizen of What Country? 2714 South Advent Court 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced I Health and Mental Hygiene. item 27 is marked other than "nature other treumatic avant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Chief - USIA US Gov't. 4+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ambrose R. Phillips, Sr. Eva Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Phillips - Wife 2714 South Advent Court, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 04-03-05 * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funery Sprice Licensee 6512 N.W. CRain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NON SMALL CELL CARCINOMA OF LEFT LUNG WITH METASTIMS Physician /Medical Due to (or as a consequence of): Examiner HYPERTENSION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ig physician and as the burial-transit The law requires that the death certificate be executed DIABETES MELLITUS Due to (or as a consequence of): Box 68760. RENKL Completed by Physician/Medical attending IF FEMALE use 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 in the past 12 months? Month Day Year 4☐Pregnant at lime of death 5 Other (specify) signed by the a d be detached fo ☐Yes 2☐No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1

Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 MNatural s after de. rel Director: Afr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide a Funerel Di Petely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fund completely fi (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

DHMH 17 Rev 1/2001

eted cause of death (Item 23a) (Type, Print)

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30. Name and address of person who comp

31. Date filed (Month, Day, Year) APR 0 4 2005

K. MICHAEL

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CHEVERLY

			1 - For State Registrar	State of Ma	aryland			t of H	ealth a				nr	5	12910
	Physic /Medi	cal	Decedent's Name (First, Middle, Las Amie V. An Facility Name (If not institution, give	Pippins			45.00		1		2. Date of Dea Month March 2	8, 2	005	Year	3. Time of Death 10:25 RM
	Exami	ner	Villa Rosa Nursing 5. Social Security Number 6. So	Home	e (In yrs. lasi		4b. City,	Mita	hellvi If Under a	ille	8. Date of Birt (Month, Da August 2	Pı		Georg	lace (State or Foreign
	Director work	_	Usual Residence of Decedent 10a. State 10b. County		91 10c. City, T	Yrs.					August 2	2, 19	213		Carolina Od. Inside City Limits
	with the Ma 3e or 28e-f	Funeral Director	Maryland Prince Geo 10e. Street and Number 10400 Woodlawn Bl				Uppe 10f. Zip	Code	1boro 20774	* * *			zen of W	hat Cour	1 XYes 2 □ No
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other traumatic event, I're Medical Exemine traust be multived at ance.	þ	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Origin, Mexican,	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race	, White,	
Maryland 21215-0036	ad within 72 ho rgiene. ar than "naturi, ine Madical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10th grade	ucation de <i>completed)</i> College (1-4or 5		life. L	ent's Usua kind of wor DO NOT us SEWITE	k done d e retired)	urina most	of worki	ng		nd of Bu	siness/Ind	dustry
ryland	hould be file d Mental Hy marked oth matic avant	To Be	17. Father's Name (First, Middle, Last) Hezekiah 19a. Informant's Name/Relationship (7			10b Mailin	a Address				Bessie	Clenc	ns		
re, Ma	s 1 and 2 s f Health an itam 27 ls i		Mr. James E. Pippins (20a. Method of Disposition	Son)		10400 e of Dispos) Woodl	awn E	Slvd. U	pper	Marlboro	, Mar	ylan	1 207	74 wn, State
Baltimore,	permit. Page Department o Important: If any injury or once.		1 Surial 2 Cremation 3 C Other (Specify 21. Signature of Funeral Survice Licen	9		Lincol	n Cerre Name and	tery Address	Apr of Facility	R	, 2005 Ollins Fu	neral	Home	, Inc	yland :.
	death certificate be executed Medical Mam Medical A for use as the burial-transit A for use as the burial-transit Medical	dical Examiner	23a Part 1. Enter the disease, or comprock, or heart failure. List only of the process of condition resulting in death) Sequentially list conditions, if any leading to the class or injury that intitated events resulting in death) Last	b. Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as:	ive Carra consequent clerotic	co not enter	or the mode	of dying	, such as o	cardiac o	ashington r respiratory arr	, Dalest,	. A	1019	Approximate Interval Between Onset and Death Years
		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3⊟	Ectopic pre Other (spe					2	3d. Date Mont	of delive h	ry Day Year
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	ding Phys h. After this funeral dir	ation; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day	y 28t	Outpatient b. Time of Injury		Other	A Nurs	sing Hon	ne 5 Reside	ence 6)
	s after safter s	I Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inju	. (Specify)					J	8f. Location (St City or Town	n, State)			
	To the Hospii within 24 hour To the Funer completely filli	Medical	(Check only one) 29b. Signature and title of certifier	rsicien: To the best of iner: On the basis of and manner sta	examination	and/or inve	estigation,	t the time in my opi	nion, death	place, a	d at the time, d	ate and p	place, ar	d due to	ated. the cause(s)
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1			Richard J. Feldman, 31. Date filed (Month, Bay, Year)	M.D. 9500	Amapol	is Roa		e #B-	4 Lanh	am, N	/aryland	2070	6		
	Sta Registr		APR 0 4 2005	Scher 1991stra	r's Signature	grand									

			Please 1 - State Registrar		ryland / Depa Ce		lealth and N	Mental Hy	_	05	12911
	Physici	an	Decedent's Name (First, Middle, Lass ALEXANDER RICHARD					2. Date of Dea	Day	Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give MALCOLM GROW MED	street and number)		4b. City, Town, o	r Location of Death	MARCE	4c. Count	2005 y of Death CE GEO	4:10P ^M
ν,	Funeral Director	~	Social Security Number 6. Security Number	7. Age	(In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)		9. Birthp	lace (State or Foreign try) CAROLINA
43			Usual Residence of Decedent					JUNE J	, 1944		
	deeth with the Maryland ims 23a or 28a-f show Frast be rediffed at	ctor	MARYLAND CHARLE	S	WALDORF	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Director	10e. Street and Number 2206 BRIDLE PATH	DDTVE		10f. Zip Code	06.01		10g. Citizen of		
920	after or Ite	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent E	0	Was Decedent of H f Yes, specify Cuba	0601 lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	UNITE	ce - Americ ack, White,	an Indian, etc.
5-0	72 hours "natural",	eted	15. Decedent's Ed (Specify only highest gra-	ucation	16a. Dece	tent's Usual Occup	ation during most of work	kina	16b. Kind of E		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other than "natural', cother traumatic avent, Ite Medical Exa	Completed	Elementary/Secondary (0-12)	2 YEARS	life.	DO NOT use retired INITILIGE	1)		FEDERA	L GOV	ERNMENT
pu	be filectal Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam				
ryla	hould d Men marke matic	일	CHARLES COLLINS 19a. Informant's Name/Relationship (7)	vne Print)	19h Mailie	ng Address (Street		ICE PARK			Codel
	and 2 s alth an 127 is er trau		ETHEL F. PARKER /	WIFE		BRIDLE PA					20601
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		20a. Method of Disposition 1 4 Burial 2 Cremation 3 4 4 Donation 5 Other (Specify		20b. Place of Dispo	sition (Name of natory or other place	(e)	Date	20c. Location	- City or To	wn, State MARYLAND
Balti	permit. Departm Importa any inju		21. Sing ture of Funeral Service Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary Licentary	see Jul	3 3	DRNION FUN 39 LIVINGSI	RAL HOME,	 Р.А.			
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or companies, or heart failure. List only disease or condition resulting in death) Sequentially list conditions,	a. PULMONA Due to (or as a	the death. Do not ente. RY EDEMA consequence of):						Approximate Interval Between Onset and Death 3 DAYS
68760,	death certificate be executed e attending physicien and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. SEPSIS	consequence of):						5 DAYS
P.O. Box 6	es that the death certificate igned by the attending phys be detached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	ry Day Year
	- w -	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.		obacco use con 'es 2□No		e cause of death? abiy 4 Xunknown
al Records,	10	Completed						24a. Was a autop perfor 1 Yes	sy med?		esy findings available apletion of cause of
of Vital	Physician: this certificant	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	it 2 ☐ ER/Outpatien	t 3 DOA Othe	26. Place of Deat	th <i>(Check only or</i> ome 5 ☐ Resid	=100	ner (Sneoite	
ion of	nding Phys ath. r: After this e funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time of	28c. Injun Work		28d. Describe h)
Division	al or Attendi s after death. Il Diractor: A od in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuit building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Town		ber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and made,	anner as sta and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and little of certifier			29c. License	number		29d. Date signe		Day, Year)
6			30. Name and address of person who d	A-NUTO-			07737	0-6	APRO	1 0	5

State Registrar David A. Norton 1050 West Perimeter Road AFB, Camp Spring, Maryland 20748

			1 - For State of Maryland / Depart Certif	tment of Health and M		2003 12912								
	8		Decedent's Name (First, Middle, Last)	neate of Death	Reg. 2. Date of Death	No. 3. Time of Death								
	Physici		Cordon Farl Phillips			Day Year								
	/Medic Examin			4b. City, Town, or Location of Death	riai Cii 20,	4c. County of Death								
	<u> Lagrin</u>			Annapolis		Anne Arundel								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country)								
	Director		577-30-3659 A Yrs.	Totals Days Flours Will.	8. Date of Birth (Month, Day, Ye June 21,	1927 Maryland								
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion		10d. Inside City Limits								
	Maryl	ō				1 TYPes 2 □ No								
	r 28e	rect	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?								
	13e o	Funeral Director	421 Hamlet Club Drive #304	21037	US									
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Processed in Fig. 13. Was	as Decedent of Hispanic Origin? (Speres, specify Cuban, Mexican, Puerto		14. Race - American Indian,								
90	or Ite	y Fu		Yes 2 No Specify:	nican, eic.)	Black, White, etc.								
Ö	hours turel',	ed by	Year or Dates: '45-'47			Specify: White								
5	in 72 "na" r	Completed	15. Decedent's Education 16a. Deceden (Specify only highest grade completed) (Give king in the DO	nt's Usual Occupation nd of work done during most of worki NOT use retired)	na l	. Kind of Business/Industry nited States								
212	iene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) One ration	ing Engineer		deral Government								
פ	be filed within 72 hours after death with the Maryland hal Hygiene. do other then "naturel", or items 23e or 28e-f show event. The Medical Exations in milital at	BeC	17. Father's Name (First, Middle, Last)		(First, Middle, Maid									
/lar	should by	To E	George W. Phillips	Amy Jone	S									
Maryland 21215-0036	2 sho and ! is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or Rura	l Route Number, Ci	ty or Town, State, Zip Code)								
2	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Madical Examination at Le molfilled at once.		Dorothy E. Phillips/ Wife 421 Ham	nlet Club Drive #										
Baltimore,	Pages 1 nent of H ant: If ite ury or ott		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State			. Location - City or Town, State								
Ë	permit. Page Department Importent: If any injury or once.	ntwood, MD												
Bal	permi Depa Impo any ir	D 1												
			23a. Part1. Enter the disease, or complications that caused the death. Op not enter t			MD 20/15 Approximate								
			Immediate Cause (Final	and mode of dying, Such as cargiac o	r respiratory arrest,	Interval Between Onset and Death								
	Pnysician /Medical		dispass of condition	cip										
	Examiner													
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):											
	ecuter and trans	Examine	cause. Enter Underlying Cause (Lisanse or flu y that initiated events resulting in death) Last Due to (or as a consequence of):											
8760,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):											
687	physics the I	dical	d											
Box	eath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery								
ă	death certific e attending p id for use as	Physician/Me	in the past 12 months? 1 Vas 2 No 4 Pregnant at time of death 5 Of	topic pregnancy ther (specify)		Month Day Year								
O.	at the de by the a stached	hys	9 ☐ Unknown											
	The law requires that the te has been signed by thoage 2 should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the under	orlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?								
ord	equir sen si sould	ted	Chrose Obstectice Full	ronory Viseas	1 ☐ Yes	2 No 3 Probably 4 □Unknown								
Records,	a law nas b e 2 st	Completed		<i>l</i>	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of								
<u>=</u>		Co			performed 1 ☐ Yes 2 💢									
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death										
ō	Physic this sral di	٠. To	1 Yes	3 POX 4 Nuising Hon	ne 5 Residence 8d. Describe how in	6 ☐Other (Specify)								
<u>0</u>	nding I tth. r: After e funer	atior	Natural 5 Pending (Month, Day Year) Injury	28c. Injury at 2 Work? M 1 □ Yes 2 □ No		,,								
Division of	• Attendi er death. • Sctor: A by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural Route Number,								
Ξ	itel or A	Cer	- Danang, did (appearly)											
	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only and an analysis of examination and/or invest	curred at the time, date and place, a tigation, in my opinion, death occurre	nd due to the cause id at the time, date a	(s) and manner as stated.								
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title & certifier	29c. License number		Date signed (Month, Pay, Year)								
	F 8 7 8		1- 7 MD	105518	7 -	3/30/								
			30. Name and address of person was completed cause of death (Item 23a) (Type, Prin	11)	T	5/29/05								
			A in e = Yu Anne	Arradel M	امتا	Center.								
*	Stat		31. Date filed (Month, Day, Year) 32. Pigistrar's Signature		01-0-									
ý.	Registra	ir	MAR 3 0 2005	343/										

				for State Registrar	State of	Maryland		rtment of I	Health and M		giene ()	15	12913			
		Physic /Medi		Decedent's Name (First, Middle, L WALTER LINWO	OD RICE					2. Date of Dea		Year	3. Time of Death 6:38A M			
	1	Exami	ner	4a. Facility Name (If not institution, g Upper Chesapeake	Medical	Center		4b. City, Town, o	Pel Air		4c. County Harf	ord				
	L	Funeral Director		5. Social Security Number 6. 216-52-9776 Usual Residence of Decedent	Sex 7. 1 X M 2 ☐ F	. Age (In yrs. Ia	Yrs.	Months Days		8. Date of Birt (Month, Day 9/9/19	h, Year) 948	9. Birthpl Coun Maryl	lace (State or Foreign try) Land			
		ne Marylan 8a-f ehow	Director	10a. State 10b. County PA York			Town or Loc elta	eation				10	0d. Inside City Limits 1 ☐ Yes 2X No			
00		th with the 23a or 2	al Dire	10e. Street and Number 374 Ridge Roa	đ			10f. Zip Code 173	314		10g. Citizen of V USA	Vhat Coun	try?			
0638	5-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In the Meryland should help the "neture", or Items 23e or 28e-f ehow umatic event, the Medical Evaniner mant be notified at	d by Funeral	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 XYes 2 If Yes, Give Year or Date	es? □No	1	/as Decedent of H Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - America k, White, e	etc.			
	21215-(be filed within 72 hou ital Hygiene. Id other then "neture event, the Medical E	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4	or 5+)	16a. Deced (Give) life. D		pation during most of worki d)	ng	16b. Kind of Bu	siness/Ind				
	Maryland 2121	uld be file fental Hy rked oth	To Be		7. Father's Name (First, Middle, Last) Ernest Jerome Rice 18. Mother's Name (First, Middle, Maiden Sumame) Edith Jackson											
6		od 2 Ith a 27 is		19a. Informant's Name/Relationship (Type, Print) Arlene Webster/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Griffith Road, Delta, PA 17314 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 1 Chestnut Grove Cemet. 4/13/2005 Street. MD												
1210.	Baltimore,	of Horizon														
1/7	Balt	permit. Pag Department Importent: I any injury o		21. Signatu A Funeral Service Lice	houle	els	100	Name and Addre	ral Home,Inc	., 600 Ma	in St., I	elta,	PA 17314			
#381753	8760,	The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires the law requires the law requires the law requires that the law requires the law requires the law requires the law requires that the law requires the law req	dical Examiner	23a. Part1. Enter the disease, or concock, or heart failure. List online disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aHe Due to (or Due to (or c.	as a conseque	ence of):	r the mode of dyir		r respiratory arı	est,	7.	Approximate Interval Between Onset and Death 2 Hours			
Pa	.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		n 2 Fetal d	death 3 □l	Ectopic pregnancy Other <i>(specify)</i>	/		23d. Date Mon	of deliver	y Day Year			
INWOOC	Records, P.	w requires that been signed t should be det		Part II. Other significant conditions Hemoperite	contributing to deat	h but not result	ting in the und	derlying cause giv	en in Part I.	23e. Did to			e cause of death?			
7	al Rec		Completed by							24a. Was a autops perform	ned2 d	rior to com eath?	sy findings available pletion of cause of			
Walter	ion of Vital	ing Phys After this uneral di	To B	P 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)												
ارح	Division	or in l	Certification:	3 Suicide 6 Could not 4 Homicide determined	280. Place of	Injury - At hom , etc. <i>(Specify)</i>	e, farm, stre	et, factory, office	2	8f. Location (St City or Town	reet and Numbe n, State)	r or Rural	Route Number,			
Big		To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier TX Certifying P (Check only one) 2 Medical Exa	nysician: To the be spinor: On the basi and manner	s of examinatio	edge, death on and/or inve	occurred at the tin stigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cand at the time, d	ause(s) and mar ate and place, a	ner as sta	ted. the cause(s)			
		To the haithin 24	M	29b. Signature and title of certified	Zall	aa	f My	29c. License	24070	2	April	(Month, D	ay, Year) 2005			
	_	12		30. Name and address of person who Ashok K Naro	completed cause of M. D.	of death (Item 2	Sa) (Type, P	rint)		rive Sta	e, 308. I	Bel A	ir, MD 21014			
	F	Sta Registr		31. Date filed (Month, Day, Year) APR 15	2005	istrar's Signatu	re	enti			/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 29, Lucy Ashley Richards 2005 4:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Yrs. Director April 16 1912 North Carolina 218-34-5433 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or Items 23e or 28a-f ehow the Medical Examiner must be notified at 1 XYes 2 □ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Russell Avenue #208 20877 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or Iten any injury or other treumetic avent, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wade C. Ashley Myrtle Perry ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Ashley Richards / Son 10421 Flowerfield Way Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State March 30, ° 4 □ Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia 2005 21. Sign ure if funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Gaithersburg, MD 20877 10 E. Deer Park Dr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician a Congestive Heart Failure 3 Weeks /Medical Due to (or as a consequence of): **Examiner** Diastolic Dysfunction Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension; Chronic Atrial Fibrillation Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Recent Pulmonary Embolism; Chronic Anemia; 24a. Was an Hypothyroidism; Chronic Hip Infection 1 ☐ Yes 2 ☐ No 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check on one Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ₺No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai The desired in the desired reading knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 ☐ Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number It Laket Derechbas March 29,2005 well) D04115 Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robert Birschbach, M.D. 201 Russell Avenue Gaithersburg, Maryland 20877

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

31

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** M) SANCHEZ MARY 2005 /Medical MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12707 CLARKS CROSSING DRIVE CLARKSBURG MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 3 1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1□ M 2**X**F Colombia 122-34-2368 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Itam 27 is marked other than "natural", or Itema 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location f Health and Mental Hygiene. Itam 27 Is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Florida Lake Leesburg Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32703 Westwood Loop 34748 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Colombian White 12 Yes 2 □ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Systems Consultant Systems Integration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rodriquez Benito Maria Rojas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeannie S. Porterfield/Daughter 12707 Clarks Crossing Drive, Clarksburg, Md. 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or oti 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crem. 3/31/05 Alexandria, Va. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Enysician Overtan Caremaric /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit igned by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐ Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificete 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Daughter S Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home 1 ☐ Yes 2 📉 No Hospital: rs after deam,
ral Director: After this c P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di

State

Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2005

PaulBannes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



0

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

18111 Prince Philip Drive, #327, Olney, Md.

D0060335

29d. Date signed (Month, Day, Year)

March 31, 2005

			For State Registrar	State of Ma	arylan		rtment of H				giene Reg. No.	UUU.	12916
	Physici /Medic	al	Decedent's Name (First, Middle, I A A Facility Name (If not institution, g	Edwa	rd		Stua 46. City, Town, or	rt.	III N	Date of De Month	Day		05 1526 M
	Funeral Director	ier	5. Social Security Number 6 217-52-0879	Hopkins		SPHal last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	re (Date of Bir Month, Da 0/24/	16	Daltis 9. Bi	MOY C rthplace (State or Foreign country) Laware
	e Maryland Ba-f ahow diffed at	Director	Usual Residence of Decedent 10a. State 10b. County MD Dorch	ester	10c. City	y, Town or Lo	urlock						10d. Inside City Limits 1 X Yes 2 No
	leath with the ns 23e or 2:	Funeral Dire	314 Penn Street 11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V	10f. Zip Code 2164 Vas Decedent of H		gin? (Speci	tv Yes or No	Uni	izen of What C ted Sta 14. Race - Am	tes
9000	d within 72 hours after death with the Maryland jiene. I then "natural", or Items 23a or 28a-f ahow Itte Medical Examilier i utalitie dal	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	Specify:	i, Puèrto Ri	can, etc.)		Black, Wh	White
Baltimore, Maryland 21215-0036	d within piene. r than	Completed	15. Decedent's (Specify only highest of Specify only highest of Specify only 12)	rade completed) College (1-4or 5	+)	Sales	ent's Usual Occupa kind of work done of DO NOT use retired	during mosi)			E16		Company
ıryland	be be ave	To Be	17. Father's Name (First, Middle, La William Edward 19a. Informant's Name/Relationship	Stuart, Jr	•	19b. Mailin	g Address (Street a	Edn	a Pau		ramp	oton St	uart Collins
re, Ma	1 and 2 Health a am 27 is thar trau		Edna P. Collins,		20b. P	4911		n Cor		d., F∈	edera		, MD 21632
altimo	permit. Pages Department of I Important: If it any injury or o		1 🗷 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Lice) 21. Signature of Funeral Service Lice	cify)		nior O	rder Cem	. (04/02, ^y Framı			ston, Ma	
8	8 2 5 8		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lir	the death	Г	ederarsh	irg, i	MD 216	032		ar nome	Approximate Interval Between
	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	pert	uence of):	Hemo	rcag	و				Onset and Death 3 days 10 years
68760,	death certificate be executed e attending physician and id for use as the burial-transit	edical Examine	that initiated events resulting in death) Last	c	a consequ	uence of):							
.O. Box		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				2	23d. Date of de Month	livery Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the un	derlying cause give	en in Part I.			obacco u Yes 2[o the cause of death? robably 4 Dunknown
Vital Record	The law ate has b page 2 sl	e Completed	25. Was case referred to medical					00 FI	4.D	1 ☐ Yes	osy rmed? 2 No	24b. Were a prior to death?	utopsy findings available completion of cause of
o	Phys this ral dir	To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Impatie 28a. Date of Injur (Month, Day		ER/Outpatient		or: 4□ Nu	rsing Home	5 Residue. Residue. Residue.	dence 6	5 □Other (Spe	ocify)
Division	I or Attanding Phater death. Diractor: After the in by the funeral	Certification;	1 X Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not determine	on be an Blace of Isin	ıry - At ho	Injury me, farm, stre		:? /es 2 □ t	No		Street and	d Number or R	ural Route Number,
	Hospita 4 hours Funeral ely filled	edical Ce	29a. Certifier (Check only one) 1 Certifying I	Physician: To the best of aminer: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and pinion, deat	d place, and th occurred	I due to the at the time,	cause(s) date and	and manner a place, and du	s stated. a to the cause(s)
į	To the within 2. To the complete	Me	29b. Signature and titla of certifier	1/400	MIS		29c. License		0		29d. Date	e signed (Mon	th, Day, Year)
			30. Name and address of person wh	600 1	V.	Wolfe	Print) S.E.	Bal	10 timor	2 /	MD	ZIZ	287
:	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 20	39. Registra			31						

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Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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			1- State of Maryland / Depa	rtment of Health and Me tificate of Death		2005	12017
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death	Noi- V V V	3. Time of Death
	Physici		JOHN FRANKLEN STAFFORD	Δ	Month Dril 05	Day Year 2005	12:52P ^M
-	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Civista Medical Center	La Plata		Charles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ⋈ M 2 □ F	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		219-46-6767 TWM 2UF 61 Yrs.		[AR.10,]		NNESSEE
	land ow		10a. State 10b. County 10c. City, Town or Loc	eation			10d. Inside City Limits
	Mary Ff sh	tor	MARYLAND CHARLES PORT TO	DAGGO			1 ☐ Yes 2 🎇 No
	h the	irec	MARYLAND CHARLES PORT TO 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	th wil	Funerai Director	7995 JOHNS PLACE	20677	T	L.S.A.	
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ri	ifv Yes or No-	14. Race - Amer Black, White	
36	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No	☐ Yes 2∑No Specify:	,,	Specify:	
8	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itams 23a or 28a-f show ant, the Medical Examber must be malified at	ed b		ent's Usual Occupation	4.01	W	HITE
21215-0036	in 72 n "na Nedic	Completed	(Specify only highest grade completed) (Give k	sing of work done during most of working O NOT use retired)	7	. Kind of Business/li IISCELLA	
212	d with giene	HO.	Elementary/Secondary (0-12) College (1-4or 5+)	D SUPERINTENDEN	7.7	ETALS,	
	e file at Hy l othe vant,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (1		
<u>a</u>	Ments Ments arked	To E	DEWEY JAMES STAFFORD	ROSA LE	E CARME	N	
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number or Rural I	Route Number, Cit	y or Town, State, Zi	p Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be codified at once.		DOTTIE LOU STAFFORD-WIFE 7995 20a. Method of Disposition 20b. Place of Dispos	JOHNS PLACE, FO			
ية	ages on of the		1 Burial 2 □ Cremation 3 □ Removal from State Cemetery, cremit	ition (Name of Dat atory or other place)	20c.	Location - City or T	own, State
Baltimore,	urtme artme ortani injury		04 Cignature of Europeal Consists Lineares	ETH. CEM. 4-11 Name and Address of Facility	-05 PI	SGAIL, MA	AVLAND
Ba	permi Depa Impo any i		MOO479 22.	RAYMOND FUNERAL	SERVIC	E, PA	
	y (23a, Part1, Enter the disease, or complications that caused the death. Do not enter	LA PLATA, MARYL rithe mode of dying, such as cardiac or r	AND 206 espiratory arrest,	46	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	0	-1		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Cul Cul Cul Cul Cul Cul Cul Cul Cul Cul	ary in use			
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	sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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687		edicai	d.				
Box	death certifi e attending d for use as	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
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õ	neen hould	eted			1 L Yes	2 □ No 3 □ Prol	pably 4 dinknown
Records,	0 - 0	Completed			24a. Was an autopsy performed?	24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
ē	ician: Th certificate ector, pag	ပို	25. Was case referred to medical		1□ Yes 2Ø1		2 No
5		0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 DER/Outpatient	26. Place of Death (Control of		6 Cother (Carry	
פֿ	g Physie ier this	L:	27. Manger of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28c	d. Describe how in	ury occurred	y)
<u>0</u>	uttanding I death. ctor: After y the funer	atio	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital	tal or Attandi s after death. al Diractor: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office 28f	Location (Street a	and Number or Rura	al Route Number,
	spital cours at naral D						\\
	Hosp 24 ho Fung stely f	Medicai	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	occurred at the time, date and place, and stigation, in my opinion, death occurred	due to the cause at the time, date a	s) and manner as s nd place, and due to	tated. the cause(s)
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
	r s r o		1 hawake	D-0056949	Li	15-105	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint)	7	1-1-	
	111		Kamakshi, Baig,MD 6620 Crain Hwy	Ste. 102 La P1	ata.MD	20646	
	Sta	_	31. Date filed (Month, Day, Year) 32. egistrar's Signature		7		
	Registra	i	APR 1 5 2005 House # 600	42.			

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year Month **Physician** STONE, SR. APRIL 2005 4:00 JAMES MARTIN 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES 6150 FOSTER HUGHESVILLE LANE If Under 1 Year It Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1X M 2□ F 63 FEB.19,1942 WASH Director 578-56-8591 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo HUGHESVILLE MARYLAND CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20637 U.S.A. or Itams 23a 6150 FOSTER LANE Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed XXX Divorced WHITE natural'. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) OWN SELF 10 MECHANIC if Health and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be JOSEPH FRANCIS STONE CLEO ELIZABETH KENDRICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7308 CARROLL DRIVE, BRYANS ROAD, MD 20616 JAMES P. STONE-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ST.PETERS CHURCH CEM.4-12-05 WALDORF, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oronar RUN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ tate has been significant based and bearings and based and bearings are seen significant. 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy, performed certificate 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Y Residence 6 Other (Specify) Hospital: 2 1 Tes **≥**□ No 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After t Hospital or Attending 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. Accident 28t. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) determined filled in by 4 | Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date tiled (Month, Day, Year) gistrar's Signature 32. State APR 1 5 2005 Registrar

			. For		Maryland / De			•	-	
			1 - State Registrar		С	ertificate	of Death		g. No. UU5	12919
	Physic	ian	Decedent's Name (First, Middle)					2. Date of Death	Day Yea	3. Time of Death
	/Medi Exami		Ada Josephi 4a. Facility Name (If not institution,			4h City To	own, or Location of Dea	Mpril	4c. County of De	12:45 HM
	Examil	ier	Washington Cour	-	-		erstown	1(()	Washin	
	Funeral			6. Sex 7.	Age (In yrs. last birthda	y) If Under 1				Birthplace (State or Foreign Country)
	Director		195–16–3043	1 ☐ M 2 💆 F	92 Yrs.	Wioridis	Day's Hours Will	Jan 26,	1913	MD
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Many e-fah	tor	MD Wash	ington	Smith	sburg				1 ☐ Yes 2 XNo
	or 284	Funeral Director	10e. Street and Number			10f. Zip C	ode	10	g. Citizen of What	Country?
	ath w	rai	14444 Edgemon				21783		USA	
	ltams	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decede	s?	 Was Deceder If Yes, specify 	nt of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- no Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
036	urs af	þ	3 Vidowed 4 Divorced	ed 1 Tyes 2 If Yes, Give Year or Date		1 ☐ Yes 2 ☐	No Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28e-f ahow tta Mudical Examiner must be notified at	Completed	15. Decedent' (Specify onfy highest	s Education	16a. De	edent's Usual E	Decupation	orking 1	6b. Kind of Busines	ss/Industry
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2	filed with Hygiene. Ither than		17. Father's Name (First, Middle, L	ast)		Machine	operator	ame (First, Middle, M	Clothing	mfg.
a	ould be Mental arkad o	To Be	Jacob Elvin Fl					na P. Deal	,	
Maryland	S D E E	-	19a. Informant's Name/Relationsh		19b. Ma	iling Address (S	Street and Number or F			, Zip Code)
	1 and 2 Health a lem 27 is		Blanche L. Gilb	ert dau			ewood Dr. H	Hagerstown	, MD 217	40
Baltimore,	of of		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 🔀Removal from Sta		ematory or other	er place)	5.7	oc. Location - City of ashington	rri
III III			4 ☐ Donation 5 ☐ Other (Sp21. Signature of Funeral Service L	ecify)	Harbaugi	n Church	h Cem. Apr	13 ZUU3	I-I C	754
Ba	permit. Departr Importe any inje		XIA neth M	Mare		ZZ. Name and A	Address of Facility G	rove-Bower	sox Fune:	ral Home, Inc
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Вох	death certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregr			23d. Date of d Month	elivery Day Year
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ord	w require been sig should b							1 🗆 Yes	2 □ No 3 □ F	Probably 4 Unknown
Records,	has be	Completed						24a. Was an autopsy	24b. Were a	autopsy findings available o completion of cause of
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	I or Attanafter deatl	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of I	injury - At home, farm, s	treet, factory, of	ffice	28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
Ω	pital o		1770							
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis and manner	st of my knowledge, dea of examination and/or	ith occurred at the nvestigation, in	he time, date and place my opinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner a and place, and du	as stated. le to the cause(s)
	Fo the	Me	29b. Signature and title of certifier	and marrier		29c. Li	cense number	290	I. Date signed (Mor	oth, Day, Year)
			•		1	D	006223		4/8/25.	
			30. Name and address of person w	no completed cause of	death (Item 23a) (Type	Print)	006223 Hager	-c+111111	marul	2. n.d
	7		Lr Bolarur	0	Mill S	treet	mag 1	>10001	mary	~,,,,
	Sta Registra		31. Date filed (Month, Day, Year) APR 15	2005 32. gis	strar's Signature	Sand a				
			WLV T 9	7002	10 10 16	A17-36-				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Dey Month **Physician** Alma Crusingberry Sale March 31, 2005 10:00 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Larkinchase Nursing Home Bowie Prince George's If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 □ M 2 💢 F Yrs 578-42-2365 Director 30, 87 Nov. 1917 Virginia Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or Nema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nothed at 1√2 Yes 2 □ No Maryland Directo Prince George's Lanham 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4610 Timber Lane 20706 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status 14. Race - American Indian. Black, White, etc. ☐ Yes 2½ No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Completed by 3₺ Widowed 4 Divorced Yeer or Dates: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Myrtle Slagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mary Pometto (Daughter) 4610 Timber Lane, Lanham MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Cheasapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/2/2005 Beltsville, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Euneral Service Licenses 9013 Annapolis Road, Lanham MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examine attanding physician and for usa as the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of) signed by tha a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ŪUnknown 1 ☐ Yes 2 ☐ No þ been sign Completed 24a. Was en autopsy perlomed? 24b. Were autopsy findings available prior to completion of cause Be 2

Attending Physician: The law requires that the death certificate be asscuted Division of Vital Records, P.O. Box 68760. Certification: To this funeral After after death. the à 5 fillad in ! To the Hospital o within 24 hours af To the Funeral D

3altimore, Maryland 21215-0020

								of death?	
						1 ☐ Yes	No	1 ☐ Yes 2 ☐ N	0
5. Was case referre examiner?	d to medical			2	6. Place of De	eath (Check only one)	/		
1 ☐ Yes 2 ☑ N	0	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other:	Nursing	Home 5 ☐ Residence	6 □Othe	or (Specify)	
7. Manner of Death 1. Natural 2 Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury a Work? 1 ☐ Ye		28d. Describe how in			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, fa	ctory, office		28f. Location (Street City or Town, St	and Numbe	er or Rural Route Numbe	∍r,

nd title of certifier 29b. Signature

(Check only one)

29a. Certifier

edicai

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted.

29c. License number 29d. Date signed (Month. Dav. Yeer)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TYA CHOPRA, M.D. 600 Ridgely Ave. Ste. 23 | Annapolis, MD. 2149 32. Registrer's Signature

State Registrar

completely

9

DHMH 17 Rev 1/2001

Registrar

	1 - State Registrar		f Marylar	-	rtificate			· · · · · · · · · · · · · · · · · · ·	Reg. No.	1005	1292
	1. Decedent's Name (First, Middle	Last)						2. Date of Month	Death Day	y Year	3. Time of Death
an cal	Robert Richa							Marc	h 27,	2005	6:13pm
ier	4a. Facility Name (If not institution,		mber)				ation of Dea	ath		County of Death	
	Holy Cross Hosp 5. Social Security Number	ital 6. Sex	7. Age (In yrs.	last highday		ver S	pring Under 24 Hi	'S R Data of		ontgomer	
	190-36-9608	11X1 M 2□F	7. Age (iii yis.	Vre			ours Mi	n. (Month	Day, Year)	Coi	nplace (State or Fore untry)
	Usual Residence of Decedent		<u> </u>	/				Мау	4, 194	i/ Wayn	esburg, P
	10a. State 10b. County		10c. Cit	ty, Town or L	ocation				****		10d. Inside City Lim
cto	MD Montgo	mery	Sil	Lver Sı	pring						1 ☐ Yes 21⁄2
Director	10e. Street and Number				10f. Zip C	ode			10g. Citi	izen of What Cor	untry?
rai	3025 Memory Lane				2090				U.S		
Funerai	11. Marital Status	Armed Fo		J.S. 13.				Specify Yes or orto Rican, etc.		 14. Race - Amer Black, White 	
by F	1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Vac Gi		966	1 ☐ Yes 25	No Sp	pecify:			Specify: Whi	te
ed G	15. Decedent	s Education	1904-1	16a. Dece	edent's Usual (Occupation	1		16b. Ki	ind of Business/l	ndustry
pie	(Specify only highest Elementary/Secondary (0-12)	college (1	1-4or 5+)	(Give	e kind of work DO NOT use	retired)	g most of w	orking	1		
Completed	12			House	e Paint	ter			Se1	f Emplo	yed
Be	17. Father's Name (First, Middle, L	.ast)				18.	Mother's N	ame (First, Mio	dle, Maiden	Sumame)	
ု	Robert Henry					-	Merced		lson		
	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ing Address (S	Street and f	Number or I	Ru <i>ral Route N</i> u	mber, City o	r Town, State, Z.	ip Code)
	Gary Alva Taylo 20a. Method of Disposition	r Br	other		Memory		e, Sil	Lver Sp		MD 2090	
	1 ☐ Burial 2 🛣 Cremation		State Che	cemetery, cre esapeal	matory or othe ke	er place)	1			ocation - City or I	
	'4 □Donation 5 □ Other (Sp		Cre	emator	y, Inc.	•		1-2005			Maryland
	21. Signature of Funeral Service L	MC .	M00956	T	hibadea	Address of	rtuary	Servi	ce, P.	Α.	0010
	23a. Part1. Enter the Jisease, or	complications that of				t Ave.	وبلطوء	Silver	Sprir	ng, MD 2	0910
	Immediate Cause (Final disease or condition resulting in death)	a. META	each line. ASTATIC (or as a conseq	NON-SI					y arrest,	-	
ai Examiner	disease or condition	a. META Due to b. LEFT Due to c. CHRO	ASTATIC	NON-SI quence of): ATELEC' quence of): STRUCT	MALL-CI	ELL LU	UNG CA	ANCER	y arrest,		Interval Between
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o Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	a. META Due to b. LEFT Due to c. CHRC Due to d. 23c. If yes, out 1 Live b 4 Pregn 9 Unknowns contributing to do	ASTATIC (or as a consequence of LUNG A) (or as a consequence of pregnation of pregnation of pregnation of pregnation of the composition of the com	NON-SI juence of): ATELEC' juence of): STRUCT juence of): ancy al death 36 jeath 56	MALL-CI TASIS IVE PUI □Ectopic preg □ Other (spec	LMONAI gnancy gnancy use given in	UNG CARY DIS	23e. D 24a. W 24a. W 1 Ve	id tobacco u Y Yes 2[Yes an utopsy	Month se contribute to No 3 □ Pro 24b. Were aut prior to codeath? 1 □ Yes	the cause of death? bably 4 Dunknot oppy findings availation of cause 2 No
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edical Certification; To Be Completed by Physician/Medical Examin	disease or condition resulting in death) Sequentially, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. META Due to b. LEFT Due to c. CHRO Due to d. 23c. If yes, out 1 Live b 4 Pregn 9 Unknown as contributing to de ation of be 28e. Place building	ASTATIC (or as a consequence of LUNG A consequence of pregnation of pregnation of the consequence of the con	NON-SI quence of): ATELECT quence of): STRUCT quence of): ancy al death 3[death 5[death	MALL-CI TASIS IVE PUI Ectopic preg Other (spec	LMONAI consider the time, data	Part I. Place of Do Nursing	23e. D 24a. V an p 1	id tobacco u Yes 2 As an atopsy afformed? s 2 No Iv one) esidence (so how injured to the cause(s)	Month Ise contribute to No 3 Pro 24b. Were aut prior to co death? 1 Yes 6 Other (Spec. y occurred d Number or Rui and manner as	Interval Between Onset and Death Onset and Death
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Maryla		artment of h		Mental Hy	/giene	2000	12923
н	Physici	-	Decedent's Name (First, Middle, Last,		- 1			2. Date of De	eath Da	y Yea	3. Time of Death
	/Medi		(atherine	Mande ?	Thoma	is		Apri	1 3		
	Examir		4a. Facility Name (If not institution, give		1.21	4b. City, Town, o	or Location of Dea	ith		. County of De	1 1
			Goodwill Me	unonite 1	Homo	Gran.	ts vill	e	(sarr	ett
	Funeral Director		5. Social Security Number 6. Sec. 270–36–7681	7. Age (In yi	rs. last birthday) 76 Yrs.	If Under 1 Year Months Days			rth ay, Year)	9. B	inthplace (State or Foreign Country)
			Usual Residence of Decedent		70			pulle 20	0,194	co riar	yland
	yland 10W		10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	Mar.	ţō	MD Garrett	F-	riendsv	i 1 1 👝					1 ☐ Yes 2√∑No
	7.288	Director	10e. Street and Number		<u> </u>	10f. Zip Code			10g. Cit	izen of What (Country?
	38 o	0	1573 Frazee Ridge	Poad		21531				TICA	
	death ms 2	Funeral		12. Was Decedent Ever in		Was Decedent of H	Hispanic Origin? (Specify Yes or No) -	USA 14. Race - An	nencan Indian,
9	after or ite	Fu	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		f Yes, specify Cub		rto Rican, etc.)		Black, Wh	nite, etc.
8	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-1 show the Medical Examinar must be motified at	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡ Yes 2 XNo	Specify:			Specify:	White
5-0	72 h	etec	15. Decedent's Edu (Specify only highest grad	cation		lent's Usual Occup		orkina	16b. K	ind of Busines	
2	□ 32	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retire	d)	nkiiig			
7	filed withi Hygiene. other than	Completed	12		Homer	naker	· · · · · · · · · · · · · · · · · · ·		Own	Home	
p	d la de	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden	Sumame)	
<u>ya</u>	D 9 2 0	ဥ	Joseph Schroyer					Meyers			
Maryland 21215-0036	C) 00 00		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City o	r Town, State,	, Zip Code)
	s 1 and of Health itam 27 other tr		Joseph C. Thomas/		900 Ht	inters Cr	cossing A	pt.108,	Ely	cia, Ot	io 44035
0	Pages 1 nent of H int: If ita iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date	20c. L	cation - City o	or Town, State
Ë	Pag ment ant: ury		'4 ☐ Donation 5 ☐ Other (Specify)		and Spri	ing Cemet	ery Apri	1 7,200	Fr	Lendsvi	lle, MD
Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service License	90	122	Name and Addre	ss of Facility Ne	wman Fur	nera.	l Homes	,P.A.
ш_	20E 29		Myan Jell	nace	P	O. Box 2	75. Gran	tsville	Mai	yland	21536
		y 172	23a. Part 1. Enter the disease, or complishock, or hear failure. List only or	cations that caused the de ne cause on each line.	ath. Do not ente	er the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	inani	tion						one month
	Examiner			Due to (or as a conse	equence of):	1. 1 5		erar -			0
		-	Sequentially list conditions, I any, leading to infraediate	Due to for as a sone	7 2 1 /4	2 heim	ers ly	re			o years
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	240 14 (0) 30 3 001101	54451165 51).						′
	xecu and al-tra	xar	that initiated events resulting in death) Last	Due to (or as a conse	equence of):	· · · · · · · · · · · · · · · · · · ·					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	ical									
687	ficate physics the										
×	certi nding use a	N/A	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg	nancy				=======================================	23d. Date of de	olivon
Вох	atter	cia	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of		Ectopic pregnancy Other (specify)	1		1	Month	Day Year
<u>о</u> .	that the death certifica ed by the attending pl detached for use as t	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					}		
	res that signed b	by PI	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did to	obacco u	se contribute i	to the cause of death?
of Vital Records,	law requires that the as been signed by th 2 should be detache							1 🗆 1	res 2	K No 3 □ P	robably 4 Unknown
8	w require s been signature should b	Completed					-	24a. Was	an	24h Were a	autopsy findings available
æ	he lav e has age 2	mc						autop		prior to death?	completion of cause of
Ø	ifficat or, pa	ပိ	25. Was case referred to medical				00 Pl (P	1 ☐ Yes		1 ☐ Ye	s 2 No
>	Attending Physician: The indeath. actor: After this certificate he the funeral director, page	ToB	examiner?	ospital: 1 ☐ Inpatient 2 {	☐ ER/Outpatient	3□ DOA Oth		ath <i>(Check only o</i>	SAINTE		
ō	a Phy eral c		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun Worl		lome 5 Resid			ecity)
<u>o</u>	th: Afte	틽	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 ∐No				
Division	Atter r dea pctor	ij	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At	home, farm, stre	et, factory, office		28f. Location (S	Street and	d Number or F	iural Route Number,
Ś	al or s afte al Dir	Certification:	4 [] Hornicide	building, etc. (Spec	city)			City or Tow	vn, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying Phys	ician: To the best of my kr	nowledge, death	occurred at the tin	ne, date and place	and due to the	cause(s)	and manner a	s stated.
	To tha h within 24 To tha f complete	Medi	one,	and manner stated.							
	5 × 5 × 2		29b. Signature and title of certifier	1	3 4 N	29c. License			29d. Date	signed (Mon	th, Day, Year)
			-1/Mm2/1	annam	- MI)	100	10.72	159	Apr	11 4,2	005
			30. Name and address of person who con	mpleted cause of death (Ite	em 23a) (Type, F	D C Ox 2 47	A	illout	MI	215	20
	Sta	Ø.	31. Date filed (Month, Day, Year)	32. Registrar's Sign		0 2 7 1	, , , , , ,	-14671			
	Registr		APR - 52	UU5 Mageer	B. A.	20062					

			1- For State of Registrar	Maryland / Dep	ertificate of L		ental Hygien	2005	12924
	Physici /Medic		Decedent's Name (First, Middle, Last) Charles	Lee Thomas Jr.		1	2. Date of Death Month Da		Time of Death
	Examin		4a. Fecility Name (If not institution, give street and num SACRE A NEAR+ M 5. Social Security Number 6. Sex	OSPITAL	Cumb	Location of Death OR OR If Under 24 Hrs. Is		County of Death	Y
	Funeral Director		212-88-3251 1 M 2 F	7. Agé (In yrs. last birthday 42 Yrs.	Months Days	Hours Min.	January 27, 19		el(State or Foreign aryland
	Maryland I-f show	tor	10a. State 10b. County Allegany	10c. City, Town or L		Lonaconing			Inside City Limits 1 ☐ Yes 2 📈 No
	h with the	ai Director	10e. Street and Number 1 Rooseveltway		10f. Zip Code	21539	10g. Ci	itizen of What Country?	
38	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evantrations to be notified at	Completed by Funeral	11. Marital Status 12. Was Dece Armed For 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year or De	2 X No	. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🗓 No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - American In Black, White, etc. Specify:	ndian, White
Maryland 21215-0036	within 72 horense. than "natural to medical to the	mpieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-12)	(Giv		ntion furing most of working nspector	16b. H	Kind of Business/Industr	,
land 2	should be filed wit nd Mental Hygiens marked other tha umatic event, Its	To Be Co	17. Father's Name (First, Middle, Last) Charles Lee Th	omas Sr.		18. Mother's Name (
Mary	and 2 shousalth and N n 27 is mai		19a. Informant's Name/Relationship (Type, Print) Genevieve Ann Thomas/ Mot	19b. Mail			-	or Town, State, Zip Coo	
altimore,	F in the Pa		20a. Method of Disposition 1 □ Burial 2- Cremation 3 □ Removal from S 1 □ Donation 5 □ Other (Specify)	tate	oosition (Name of ematory or other place berland Cremeto		e pril 02, 2005	ocation - City or Town, Cumberland, Ma	
Balt	permit. Departr Imports any Inje		21. Signature of Funeral Service Licensee			enzie Funeral Ho		n St., Lonaconing	, Md. 21539
9/60,	death certificate be executed Wedical e attending physician and of for use as the buriat-transit	dicai Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ch line.	ro-later	al my o		Inte	proximate arval Batwaen set and Death C Cay S
O. Box 6	ath certifi attending for use as	Physician/Med	in the past 12 months?	nt at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day	Year
cords, P	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to de-	th but not resulting in the t	underlying cause give	n in Part I.	23e. Did tobacco	use contribute to the ca	
T T	The lar ate has page 2	Completed					24a. Was an autopsy performed?		tion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	patient 2 ER/Outpatie	ent 3 DOA Othe	26. Place <u>of Death</u> (0		6 TOh (C	
on or	ding Phys th. : After this s funeral di	tion: T	27. Manner of Death ↑ ↑ Natural 5 □ Pending (Month) 2 □ Accident investigation		of 28c. Injury Work	at 280	d. Describe how injur		
DIVISION	al or Attending P s after death. Il Director: After t ed in by the funera	Certification:	3 Suicide 6 Could not be	f Injury - At home, farm, st g, etc. <i>(Specify)</i>	treet, factory, office	289	. Location (Street an City or Town, State	nd Number or Rural Rou b)	ıte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) Certifying Physician: To the la 2 Medicel Examiner: On the bar and manner	is of examination and/or in	th occurred at the time nvestigation, in my opi	e, date and place, and inion, death occurred	I due to the cause(s) at the time, date and) and manner as stated d place, and due to the	cause(s)
	With To t	Σ	29b. Signature and title of certifier		29c. License		29d. Da	te signed (Month, Day,	Year)
	The second secon		30. Name and address of person who completed cause Tesus Tan Rt 34	of death (Item 23a) (Type, Frostburg	Print)	Frasth.	- Mil	21532	>
k	Sta Registra	te ar	31. Date filed (Month, Day, Year) APR = 4 2005	istrar's Signature	Sports.	110-104	7,000	91331	

			1 10430	ypo or rimer	le sel (D		المحمطلاميا	Annial III.		9	
			For State	State of Mary		artment of H		nental Hy	()	005	10000
			Registrar 1. Desedent's Name (First, Middle, Last)	- 00	tillicate of t	Death	2. Date of De		000	3. Time of Death
	Physicia		DATOTOTA	ANIN	Tr	55/6		April 1	1, ^{Day}	Year)5	11:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	7 ,0		r Location of Death	<u>, , , , , , , , , , , , , , , , , , , </u>	_	ounty of Deat	
	_xuiiiii		Calvert Memorial	Hospital			Frederick			lvert	
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birti	nplace (State or Foreign untry)
	Director		220-26-6860 Usual Residence of Decedent	73	713.			Dec. 15	5, 193	si wash	ington DC
	/land		10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside City Limits
	Man e-fsh illed	tor	Maryland Calvert	P	rince Fr	ederick					1 ☐ Yes 2X☐ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code				n of What Co	
	s 23a	ral	6744 Hallowing Po	int Road 12. Was Decedent Ever	in II 6 12	20678	lispanio Origin? (Sp			d State Race - Ame	
_	item item	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	10.3.		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White	
3	ursal al', or	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		S	ресіfу: wh	ite
213-003a	should be filed within 72 hours after death with the Maryland of Mental Hygene marked other than "natural", or items 23a or 28e-f show matic event, the Modical Exertified and be notified a	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	aing	16b. Kind	of Business/	industry
7	vithin ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		itress	d)		Po	staura	nt
Z	illed v Hygie ther t	CO	12 17. Father's Name (First, Middle, Last)		Wo	itress	18. Mother's Nam	e (First, Middle			11 C
Jana	ld be ental ked o	To Be	Albert M. Gladwel	1			Sarah	Flora S	mith		
<u> </u>	should and Men s marke umatic	-	19a. Informant's Name/Relationship (7)		19b. Mail	ng Address (Street	and Number or Rui			Town, State, 2	(ip Code)
>	and 2 ealth a n 27 is		Carol L. Hooper- d				Benedict				
Ψ	of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ I		Ob. Place of Disponentery, cre	osition (Name of matory or other plac	ce)	Date		ation - City or	
	t. Pag tment tent:		'4 ☐ Donation 5 ☐ Other (Specify,)		rematory 2. Name and Addre		2-2005	Walc	lorf, M	laryland
e D	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	M01246) -		uneral Ho 156, Wa	me c	MD OO	CO# 01	
			23a. Part1. Enter the disease, or comp	lications that caused the	death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	MD ZU arrest,	004-01	Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ine cause on each ine.	COP	7					Onset and Death
	/Medical		resulting in death)	Due to (or as a co	onsequence of):			-			
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of:						
	ted nslt	nlne	cause. Enter Underlying Cause (Disease or injury	Due to (or 25 a cc	insequence or,						
<u>,</u>	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
/ PQ	ys e	cal	· ·	d							
20	w requires that the death certificate been signed by the attending phys should be detached for use as the	Med	IF FEMALE:		NAME OF TAXABLE PARTY.						
X D	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnancy	у		23	d. Date of del Month	Day Year
o O	the de	Physician/Med	1 □ Yes 2 No 9 □ Unknown	9 Unknown	o or dealtr or						
,	that hed by deta	by Ph	Part II. Dther significant conditions co	ontributing to death but no	ot resulting in the	inderlying cause giv	ven in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
ğ	requires that een signed b nould be dela							17	¥es 2□	No 3∏Pr	obably 4 Unknown
ecord	as be	Completed						24a. Was	opsy	prior to	topsy findings available completion of cause of
Ľ	sicien: The law certificate has b irector, page 2 s	Con						1 Yes	ormed?	death?	2 No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	• C 5000 to 10	Ott	26. Place of Dea			Other (See	-(4.)
0	this ald	To To	1 ☐ Yes 22 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie			ome 5 ☐ Res 28d. Describe			Siry)
slon	nding Phath. sth. r: After thi	atlor	1 Natural 5 Pending investigation	(Month, Day Ye	ear) Injury		Yes 2 No				
<u> </u>	al or Attending F after death. I Director: Alter d in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, si Specify)	reet, factory, office			(Street and own, State)	Number or Ru	iral Route Number,
	urs af erel D		200 Conflict Dendituing Dh	ysician: To the best of m	w kaowladao daa	th occurred at the ti	me date and place	and due to the	cause(s) a	nd manner as	stated
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in b	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	iner: On the basis of exa and manner stated	amination and/or it	nvestigation, in my	opinion, death occur	rred at the time	, date and p	lace, and due	to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	01.6	2 k 2	29c, Licens	se number	42	29d. Date	signed (Mont	h, Day, Year)
			1 (Solph	1 Sugar	The D	1)	70760	76	6	7/1/	103
(AD IN		30. Name and address of person who o				Duines	Enodos:	ak M	. / D 2067	0 //0//1
	Sta	ate	Joseph J. Barth, 31. Date filed (Month, Day, Year)	MD 110 H	Signature /	Ku. #310	, Prince	rreaeri	UK, I	u 200/	O=4U4T
	Regist		APR 0 2	2005	w so	and the same of th					

			For State Registrar	State of Marylan	•		it of He		nd Me	ental Hy	giene	11115	129	26
			Hegistrar Decedent's Name (First, Middle, Last)				0 0, 0			2. Date of De			3. Time of	of Death
	Physicia	an	Derwood Ste	phen Turn	or					April	1, Day	005 Year	8:10	Ам
j.	/Medic		4a. Facility Name (If not institution, give s		CI	4b. City.	Town, or L	ocation of		APITI		County of Deat		
	Examin	er	Waldorf Healthcare				Waldo					Charle		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	if Under 2	4 Hrs.	8. Date of Bi	rth			or Foreign
	Director		577-03-8210 1X	M 2□ F 88	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D.) PC • 1	3, 19	16 Was	hplace (State o junto) hingtoi	n DC
	D.		Usual Residence of Decedent											
	how	_	10a. State 10b. County		y, Town or Lo	ocation							10d. inside C	ity Limits
	Be-f	cto	Maryland Charles	Wal	ldorf									- 2Д.10
	or 24	Director	10e. Street and Number				Code				-	zen of What Co		
	ath w		70 Village Street		-		0602					ed Stat		
	er de	Funeral	V	12. Was Decedent Ever in U Amed Forces?	.S. 13.	Was Dece If Yes, spe	dent of His cify Cuban	panic Orig , Mexican,	Puerto P	cify Yes or N Rican, etc.)	٥-	 Race - Ame Black, White 		
36	, or	by F	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:		1 🗆 Yes	20 No	Specify:				Specify:	hi+a	
3	hour tural	edt	15. Decedent's Educ		16a. Dece	dent's Usu	al Occupat	tion			16b. Ki	nd of Business/	hite Industry	
Ç	in 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of wo DO NOT u	ork done du ise retired)	iring most	of workin	g				
212	filed within 72 hours after death with the Maryland Hybione. ther than "netural", or Items 23s or 28e-f show int, Ite Medical Examerar must be motified a	Completed	10	College (1-4or 5+)	Sea	aman					Mer	chant №	farine	
ַ	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)							(First, Middle				
Maryland 21215-0036	Aental Aental	ToE	Harry Derwood Turn	ier				St	tepha	anie Pe	erkin	IS		
aZ	s ma		19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Addres	s (Street ar	nd Number	r or Rural	Route Numb	per, City o	r Town, State, Z	Zip Code)	
	and 2		Maureen Parkhurst-					rive,				21228		
ore o	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, crea	nsition (Na matory or	me of other place)	Da	ate	20c. Lo	cation - City or	Town, State	
Ĕ	Peges ment of 1 ent: If its ury or o		'4 □Donation 5 □ Other (Specify)	St.	Antho	ny's	Cemet	ery (04-04	1-2005	Kir	g Georg	je, VA	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Importent: If tem 27 is marked other than "netural; or Items 23a or 28e-f show eny injury or other traumatic event, Ite Marilcal Examinar must be invitted at once.		21. Sign vuln of Funeral Service License	M00053		Name a luntt	Fune	ral H	lome	orf, M	וח אַ	604		
			23a. Parti. Enter the disease, or compli	cations that caused the deat								004	Approxima Interval Ber	ite
	Dhaminina		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.								C	Onset and	
150	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	uence of):	_						ro	V DA	71
b	Examiner													
*	PAREN	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	luence ol):									
	cutec nd ransi	Examiner	that initiated events											
760,	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a consec	quence of):							ŀ		
		Ilcal		l				-						
68 2	e as	Med	IF FEMALE:											
Division of Vital Records, P.O. Box	eath certificat attending phy I for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta	al death 3	□Ectopic p						23d. Date of del Month		Year
<u>.</u>	that the dei ned by the a detached f	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of c 9□ Unknown	leath 5L	Other (s	респу)							
<u>.</u>	hat the d by Jetac		Part II. Other significant conditions cor	stributing to death but not res	sulting in the u	ınderlyina	cause giver	n in Part I.		23e. Did	tobacco u	ise contribute to	the cause of	death?
Ŝ	w requires that been signed be should be det	by	DIARIETES		TUS		y					□No 3□Pr		
0	requ	Completed	D ₁ = , A ₁						_	24 146		0.00		
ec Sec	has t	ld u	RUNAL	FAILUR	-12					24a. Was		prior to death?	itopsy findings completion of c	cause of
<u> </u>	cate										2KNo		2□ No	
	ysicien: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	lospital:			Other	/		(Check only				7-1
o	Phys this ral dia	To.	1 Yes 2/3/No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o		OA 28c. Injury	4.KI NUI		ne 5 🔲 Res		6 ☐Other (Spec	city)	
ב	After After funer	lou	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	м	Work'	? 'es 2 □ N		.00, 200000	11011 111101	,		
<u>S</u>	death death ctor: / the	cal	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, st					81. Location	(Street an	d Number or Ru	ural Route Nun	n <i>ber</i> ,
<u>></u>	after Direction by	Certification;	4 Homicide determined	building, etc. (Speci	fy)		7, 011100				wn, State			
_	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the			sician: To the best of my knowner: On the basis of examina										(s)
	To the H within 24 To the Fi complete	ledical	one)	and manner stated.										
	E	Σ	29b. Signature and title of certifier	. 1			c. License		1			te signed (Monti		
1	S T WITH			A #		1	1 (/ / /	1112	- /		Λ	1 //		-
	T vit		1/26/04	Μ		L	944	72	96		13-6	rilo	120	20
			30. Name and a press of person who co	ompleted cause of death (Ite	m 23a) (Type,	. Print)							120	05
5	BID		30. Name and a cress of person who con Dr. Ashvin J. Pat 31. Date filed (Month, Day, Year)	el, 102 Paul	m 23a) (Type,	. Print)							120	20

JENNY VODOPIVEC Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S 05 - 2383State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** Jennie Vodopivec 2005 APRII /Medical 4a. Facility Name (If not institution, give street and number)
GARRETT MEMORIAL HOSPITAL 4c. County of Death 4b. City, Town, or Location of Death Examiner GARRETT OAKLAND If Under 1 Year If Under 24 Hrs.

Months Days Hours Min, 8. Date of Birth Month Day, Year) NOV 11 1911 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🐼 F 93 Director 097 16 4285 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f shov the Medical Examinar must be notified at Director MD Garrett Kitzmiller the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 State St death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2 Yes, Give 1X Never Married 2 Married 27 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 Is markad othar th Nurse Red CrossBlood Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Vodopivec Johanna Podvoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 Is any injury or other trau Merrilee Barlow 312 Shadow Pky Chattanooga Tn 37421 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 XDonation 5 ☐ Other (Specify) Kalbaugh Cemetery Apr. 8,2005 Elk Garden WV 22. Name and Address of Facility David A. Burdock FH 21. Signature of Funeral Service Licenses 710 Church St. Kitzmiller, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASUULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed 24a. Was an has autopsy performed 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2

Division of Vital Records,

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1.☑Yes 2□ No TV Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature and title of certifier

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) APRIL 6, 2005 OCME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 170 RUB10

111 Penn Street Baltimore, Maryland 21201

1 Yes 2 No

Year

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature 2005

After

Diractor: /

death.

after

within 24 hours at To the Funeral D

Certification:

Medical

			1 - For State Registrar	State of	f Maryla		artment rtificate			nd Me	ental Hyg	iene	05	12928
			Decedent's Name (First, Middle, L.)	ast)						1	2. Date of Deat	h		3. Time of Death
	Physici /Medio]	LUISE WHI	ITE					l _N	Month March	31,	Year 2005	4:30 P M
	Examin		4a. Facility Name (If not institution, g		,		4b. City, 7	Town, or L	ocation of	Death		1	y of Death	
			11126 Hessong Bi					rmont				Fre	deric	k
	Funeral Director		220-54-4456	Sex 1 M 2 F	7. Age (In yrs	last birthday) 71 Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of Birth (Month, Day, Nov. 12	_{Уваг)} , 1933	9. Birthp Cour Germa	lace (State or Foreign try) any
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	Od. Inside City Limits
	Maryl f sho	0	Maryland Freder	1-		•								1 ☐ Yes 2 ☐ No
	288	rect	Maryland Freder 10e. Street and Number	ICK	1	hurmon	10f. Zip (Code			1	0g. Citizen of	What Cour	
	3a or	Ö	11126 Hessong Br	idge Roa	ad			1788					.S.A.	My:
	death	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in I		Was Decede	ent of Hisp	anic Origi	in? (Spec	ify Yes or No-	14. Ra	ce - Americ	
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show Jical Exain a citrust Le ricified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 ∑X No e		fYes, speci I∐Yes 2	-	Mexican, Specify:	Puerto Ri	ican, etc.)	Speci.	fy:	
Ö	r2 ho	Completed by	15. Decedent's I	Education		16a. Deced	lent's Usual	Occupation	on			16b. Kind of E		Lte dustry
218	thin 7 e. an "r	nple	(Specify only highest g Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work DO NOT use	(done dui e retired)	ring most o	of working	7			,
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Ind	be fill Ital H Id oth	Be	17. Father's Name (First, Middle, Las	st)				11	8. Mother's	s Name (First, Middle, N	faiden Sumai	ne)	
<u> </u>	ould Men marke maric	2	Unknown							nknow				
, Maryland	is 1 and 2 st of Health and item 27 Is n other traun		19a. Informant's Name/Relationship Tom L. White (Sc								Route Number, , Mary			Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the redited at once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 ↑ 4 □ Donation 5 □ Other (Spec	☐Removal from S	State	Place of Dispo cemetery, cren ica Cen	natory or oth	ier place)	1. /	Dat 4/05		20c. Location	-	
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68760,	icate phys s the	edical		d										
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Vita V	icien: Th certificate rector, pag	Φ	25. Was case referred to medical						6 Plans of	f Dooth (1 □ Yes 2, Check only one		I ☐ Yes 2	2 □ No
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) (Check only one)	hysician: To the b miner: On the bas and manne	sis or examina	wiedge, death tion and/or inv	occurred at estigation, in	the time, nmy opini	date and p	place, and occurred	d due to the cau at the time, da	use(s) and ma	nner as sta	ted. the cause(s)
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	,- ,- 0		> prosessor	somo L	MD			031	761			4/11	100	
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	/Medi Examir		4a. Facility Name (If not institution			<u> </u>	4b. City,	Town, or	Location of	of Death	April		2005 nty of Death	1. 7	, ,
1			Atlantic Ge	-				rlin				Wor	cester		
	Funeral Director		5. Social Security Number 215-16-3600	6. Sex 7	. Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Bir (Month, Da May 5	th ly, Year) 	9. Birth: Coul	place (State ontry)	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. Count	-	10c. Cit	ty, Town or Lo	ocation							Od. Inside C	ity Limits
	a-f sh	ctor	MD Word	ester		Berli	n							1 🗆 Yes	2 No
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920	u within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show Ite Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce		es? □ X No		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)		Race - Americ Black, White, cify: Whi	etc.	
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signatur / Fire Service			22	. Name and	d Addres	s of Facility	у ТН	E BUR	BAGE	FUNE		IOME
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8	T 3		30. Name and address of person	who completed cause	of death (Item	23a) (Type, 1	Print)	רג'ער	C.	Bol	1/W H	ID Z	1811		
	Sta	24	31. Date filed (Month, Day, Year,	32. Seg	istrar's Signa	ture	4	IUIV		JE1			- / •		
34.5 A	Registr	ar	APR 0 5	2005	was h	x An	ente)								

Winshow, DAVIN K. 220-26.7775

				Type or Print State of Mary						-	
			1 - For State Registrar			rtificate of L			Reg. No.	0000	10000
	Physici		1. Decedent's Name (First, Middle, Las DAVID K. WINSLOW,	•				2. Date of De Month		- UUJ-	3: Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	14/210	4c.	County of Death	1700
1		Ш	Peninsula legion	al Medical	Center	Sali	sbury			Wicom	
	Funeral Director		5. Social Security Number 6. Se 220–26–7775	7. Age (Ir	yrs. last birthday 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 07-13-1	(y, Year)	Cour	lace (State or Foreign htry) MORE, MD.
	/land		10a. State 10b. County	10	c. City, Town or L	ocation				1	Od. Inside City Limits
	a-f sh	ţo	MD WICON	1ICO	SALISBU	JRY					1 ☐ Yes 2 📉 No
	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cour	itry?
	s 23a	la	210 WHITE STREET				21804			USA	
	ter de Items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No	rin U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No Rican, etc.))-	 Race - Americ Black, White, 	
036	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1953	1 ☐ Yes 2√∑ No	Specify:			Specify: W	HITE
5-0	72 ho	eted	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupa	ition	200	16b. Ki	nd of Business/Inc	dustry
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. I then 27 is marked other then "natural", or Items 23a or 28a-f show other treumetic event, If a Medical Examinal must be natified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired))	ng			
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Maryland	ould be filed with Mental Hygiene. arked other ther etic event, IteM	To Be	SIDNEY HARVEY WINS	ST.OW			HELEN HI		TVIQ TO OTT	oumanie)	
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Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ F		Ob. Place of Disp cemetery, cre	osition (Name of matory or other place	3)	Pate		cation - City or To	
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68	rtificat ng ph) as th	led	TECTIVALE.								
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of \	Physicien: this certificatal director,	2	1 ☐ Yes 2 ☐ ₩6		2 ER/Outpatier		4 LI Nursing Hor			Other (Specify)
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Ö	al or / s after il Dire	Certification:	4 Homicide determined	building, etc. (S	pecify)	,,,		City or Tow	m, State)		
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical (29a. Certifier Check only one) Cartifying Phy 2 Madical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	and due to the ded at the time, o	ause(s) a date and	and manner as sta place, and due to	ited. the cause(s)
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)	40		MUlynza), on		1200	2567	4 4/	3/00	-	
	23		30. Name and address of person who co				1 1			nd.e	10
	1/2		31. Date filed (Month, Day, Year)	1346 J 32. Restrar's S	· Div.s	, on 14	, Val	spu.	71	nd.s	1804
	Sta Registr		APR 0 4 2	2005 Eller	w St.	berk					

DHMH 17 Rev 1/2001

		1	1 - For State of Maryland /	Department of Health and Mo Certificate of Death	ental Hygier	211115 12931
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Jane Williams		March	30 2005 1640 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		117-715-9856 1 M 2XF 45	Yrs. Months Days Hours Min.	(Month, Day, Yea	ar) Country)
			Usual Residence of Decedent			
	anylen show dat	_		vn or Location		10d. Inside City Limits 1 Nes 2 □ No
	88a-1	ecto		UCESS HNNE	100 (Citizen of What Country?
	with t	Ę	30811 - DIVISION ST	2/853	109. (USP
	ours after death with the Marylen rel', or Itama 23a or 28a-f show Examiner must be mutflied at	Funeral Directo	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - American Indian,
٥	after or Ital	F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto to 1 ☐ Yes 2 No Specify:	rican, etc.)	Black, White, etc. Specify: Rinck
5-0036	filed within 72 hours after death with the Marylend Hygiene. sther then "naturel", or Itema 23a or 28e-f show ont, the Medical Examitter must be notified at	d by			· · · · · · · · · · · · · · · · · · ·	OBICK
	"nati	Completed	15. Decedent's Education 16. (Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 	ng 16b.	Kind of Business/Industry
121	within then then then then	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	DIETICIAN	A	TARI NURSING
ַ	be filed within 72 ho ital Hygiene d other then "natur event, ire Mould	0	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	
Maryland		To B	JOHN HENRY LOOK	SARAH	PEARSIALL	DOULING
lar	2 2 2 3			b. Mailing Address (Street and Number or Rura	VA.	20
	1 and lealth om 27 ther tr		SILVAD D. WILLIAMS - HUSBADD 20b. Place	308// - Diffision ST, IRIN of Disposition (Name of	ate HNNE	Location - City or Town, State
و	0 0		1 ■ Burial 2 □ Cremation 3 □ Removal from State	ery, crematory or other place)	1 10000	ARION STATION, MD
Baltimore,	permit. Page Department Importent: If any Injury o		21. Signature of Funeral Service Licensee			WITH FIH
Ba	Dep Imp		Quel for		51. SALIS	
	Physician		23a. Part1. Lefer the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Į			Immediate Cause (Final disease or condition A 20 Xi C	encephalopothy		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence	e of):		
	Cxammer	10	Sequentially list conditions, b. — A K V S	a city		
	rted	Examiner	cause. Enter Underlying Cause (Disease or injury			
Ć	execu an and ial-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence)	e of):		
3760	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Icai	d			
39	es that the death certifics igned by the attending pt be detached for use as t	Physician/Medical	IF FEMALE:			
Box	ath cattencattenc	ian	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
P.O.	the de	ysic	1 Tyes 2 No 9 Unknown	3 Cittel (specify)		
	s that ned by e deta	by Ph	Part II. Other significant conditions contributing to death but not resulting	23e. Did tobacco use contribute to the cause of death?		
g	w require been sig should b		Diabetes Mellitus, hypert	ension, anemia	1 ☐ Yes	2 No 3 Probably 4 QUnknown
Records,	e taw re has bed je 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
m =	ysician: The is certiticate hadirector, page	Com			performed 1 Yes 2	
Division of Vital	ician: Th certiticate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
of	Physi this c	- T	1 Yes 2 KNO 1 IN Inpatient 2 ERV	Dutpatient 3 DOA 4 Nursing Hor	me 5 Residence 28d. Describe how in	6 Other (Specify)
O	ding h. After fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	Injury Work? M 1 ☐ Yes 2 ☐ No		. ,
N S	Atten r deal ector by the	Ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
	s ette el Dir ed in	Certification;	Dullang, etc. (Specify)		0.1.9 0. 1 0.1.1.1, 0.1	
	To the Hospitel or Attending Physician: within 24 hours eller death. To the Funerel Director: Atter this certilics completely lilled in by the funeral director, p	edicai	29a. Certifier (Check only Certifying Physician: To the best of my knowled Certifying Physician: To the best of my knowled Medical Examiner: On the basis of examination is	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the He within 24 To the Fu	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	\(\frac{1}{2}\) \(\frac{1}2\)		No Co MA	00062130		Narch 30 2005
	3110	Į.	30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)	442	
,	711		James Angia M.D. 1104	Healthway Dr. Salist	oury MD	21804
	Sta		31. Date filed (Month, Age Kear) 4 2005 32. Resistrar's Signature	4. Coaste		
	Regist	ar	A COUNTY	Tall and the same of the same		

Jane Williams

	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 5 1 2								5 12022	
	Physiciar /Medica		1. Decedent's Name (First, Middle, Last) Agnes D. Watson		2. Date of Death Month March, 27			Day Year 6.05 D		
	Exami		4a. Facility Name (If not institution, give street and number) 4902 Ashford Drive			Upper	Location of Death Marlboro	1	4c. County of E	eath eorge's
	Funeral Director		5. Social Security Number 6. Security Street 6. Sec	7-7	ast birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 2	9. 8 ,1 935 N	Birthplace (State or Foreign Country) brth Carolina
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatile and Mental Hygiene. artment of Heatile and Mental Hygiene. Injury or other traumatic event, I'm Madical Examiner inval be motified at injury or other traumatic event, I'm Madical Examiner inval be motified at 9.	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City L					10d. Inside City Limits ↑ Yes 2 □ No		
		Funeral Director	10e. Street and Number 4902 Ashford Drive			10f. Zip Code	20772	10	g. Citizen of What U.S.A.	t Country?
		þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1	ì	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. Black
		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th grade		(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired Ostal Clerk	during most of worl ()	sing	U.S. Post	al Service
		To Be C	17. Father's Name (First, Middle, Last) William Howard	rd			18. Mother's Nam	e (First, Middle, M Hester Aus		
			19a. Informant's Name/Relationship (Ty) Freda P. Watson (Daugh			-		Marlboro, M	* -	e, <i>Zip Cod</i> e) 10772
<u> </u>			20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State C6	metery, cren	sition (Name of natory or other place on Cemetery	ا (م		Co. Location - City Linton, Ma	
Balt	permit. Pag Department Important: I any injury o		21. A vature of Fungral Service License	Leison		. Name and Addres 39 Hunt Pla		ollins Fune ashington,		
	Inysician /Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The disease or condition resulting in death) Due to (or as a consequence of):								Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Box 6			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, P		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					co use contribute to the cause of death? 2 XNo 3 Probably 4 Unknown		
Rec		Completed						24a. Was an autopsy performe	prior i death	autopsy findings available to completion of cause of ? es 2 🖾 No
f Vital	Pnysician: the this certificateral director, participateral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No H	26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. Other. 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify)						
	Affer une	ertification:	27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigation			28d. Describe how injury occurred				
\leq		Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	to the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.					lue to the cause(s)		
9	within To the	Σ	29b. Signature and title of certifier Ethnology A	bebe mi)	29c. License		290	March 29,	onth, Day, Year) 2005
	(2)	30. Name and address of Ferson who completed cause of death (Item 23a) (Type, Print) Ethiopia Abebe, M.D. 5100 Auth Way Suitland, Maryland 20746								
	Sta Registr	_	31. Date filed (<i>Month, Day, Year</i>) APR 0 4 2005	32. Registrar's Signatu	Tree Land	U				

			1 - For State Registrar		aryland / De		of Health a	and Menta	al Hygi	-	05	12933
			Decedent's Name (First, Middle, Las	t)				2. Da	te of Death	J. NO.		3. Time of Death
н	Physic		Edward G. W	iggins Si	· .			Ma	rch :	30 ^{ay} :	20 0 5	9:05 AM
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Tov	n, or Location of	of Death		4c. Coun	ty of Death	
			Villa Rosa Nu 5. Social Security Number 6. Se	rsing Cen	ter ge (In yrs. last birthda	Mi If Under 1 Y	tchellv ear If Under		to of Rinth	Pr:		George's
н	Funeral Director			ĎM 2□F (1.0)	89 Yrs.		ays Hours	Min. (M	te of Birth onth, Day, \ Ly 4,	1915	Goun Wa	lace (State or Foreign stry) Sh., DC
			Usual Residence of Decedent		0)			043	-			J., 20
	ylan		10a. State 10b. County		10c. City, Town or	Location					1	Od. Inside City Limits
	e-f s	cto	Maryland Prince (George's		Uppe	er Marli	boro				1 AYes 2 No
	or 28	- Le	10e. Street and Number			10f. Zip Co	de		100	g. Citizen of	What Coun	try?
	afh w	by Funeral Director	12502 Mart Cou	ırt				774		Un	ited	States
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	 Was Decedent If Yes, specify 	t of Hispanic Ori Cuban, Mexican	igin? (Specify Ye n, Puerto Rican,	es or No- etc.)		ice - Americ ack, White, i	
36	s aff	Y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	Ç10	1 ☐ Yes 2 ☐	No Specify:			Speci	ity: B	lack
21215-0036	within 72 hours affer death with the Maryland ene. than "natural", or itams 23a or 28e-f show ta Medical Examinar must be notified at	edt	15. Decedent's Ed		16a De	cedent's Usual O	ocupation		16	Sh. Kind of F	Business/Inc	luetn/
15	In 72	olet	(Specify only highest grad	de completed)	(Gi	ve kind of work a . DO NOT use r	lone during most	t of working	10	D. King of L	343111033/111C	Justry
212	with jiene.	Completed	Elementary/Secondary (0-12) 10th	College (1-4or	5+)	Postal	Worker			Gov	ernme	nt
ğ	be filed within 72 hours after death with the Marylan tal Hygiene. sd other than "natural", or itams 23s or 28e-f show other than "natural", or itams 23s or 28e-f show event, the Mudical Examinat must be notified at	Bec	17. Father's Name (First, Middle, Last)					er's Name (First,	Middle, Ma	iden Suma	me)	
<u>la</u>	should be nd Mental marked o	To E	Andrew W	iggins				Ma	adelin	e Sim	ms	
Maryland	s 1 and 2 should if Heelth and Meni item 27 is marker other treumatic		19a. Informant's Name/Relationship (T	ype, Print)		iling Address (St						
	Heelth Heelth tem 27		Madeline Nowlin	- Daughte		.09 Mar11		ods Dr.	, Chel	tenha	m, MD	20623
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 1	Removal from State	20b. Place of Dis	position (Name of rematory or other	of r place)	Date	20	c. Location	- City or To	wn, State
Ē	Peges ment of ent: if it		`4 □ Donation 5 □ Other (Specify,)	Lincolr	Memoria	al Cem.				land,	MD
3all	permit. Peges Department of I Importent: if ite any injury or of		21. Signature of Furreral Service Licens	- (-	t	22. Name and A			art Fu			010
_	0 □ = 0		John	Meway	C, 11		Benning				DC 200	
١.,			23a. Part 1. Enter the disease, or comp shock theart failure. List only of	lications that caused one cause on each li	d the death. Do not e ne.	enter the mode of	dying, such as	cardiac or respi	ratory arres	t,		Approximate Interval Between Onset and Death
	Pnysician		Immediate aute (Final disease or condition resulting in death)	a. Chron	nic Lympho	cytic L	eukemia					Onsat and Death Years
	/Medical Examiner		resulting in disagn)	Due to (or as	a consequence of):						-	
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	nslt	를	Cause (Disease or injury		,							
,	t be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as	a consequence of):							
8760,	death certificata be executed e affending physician and id for use as the burial-transit	cal		d								
9	tifical											
Вох	leath certifici affending pl	N/UE	23b. was decedent pregnant	23c. If yes, outcome		B⊟Ectopic pregn	ancv				ate of deliver	
	s deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown		Other (specif				M	onth	Day Year
P.0	thef the de ed by the a detached t	Physician/Med	9 Unknown						0:1:	-		
Ś	Se LB C	by	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying cause	e given in Part I.	. 23				e cause of death?
ecord	w requires been sign should be	Completed				·			1 162	2 110	3 <u> </u>	
ec	aw 2 s	nple							a. Was an autopsy		Were autop prior to con death?	sy findings available apletion of cause of
E E	Th ate pag	Co						1	performe Yes 2			2 🗆 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Chec				
of	Phys this ral dir	T.	1 ☐ Yes 2 🔀 No	1 Inpatie			4 [2]3/101	rsing Home 5	☐ Residend scribe how)
on	ding h. Affer funer	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) Injun		Injury at Work? 1 ☐ Yes 2 ☐ N			,,		
Division	Attending r death. actor: Affeloy the fune	flca	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home, farm,			28f. Loc	cation (Stree	et and Numi	ber or Rural	Route Number,
Ö	efter efter Dire	Certification;	4 Homicide	building, et	c. (Specify)			Cit	y or Town, S	State)		
	To the Hospitel or Attend within 24 hours efter deaft To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, de	ath occurred at th	ne time, date and	d place, and due	to the caus	se(s) and m	anner as sta	ated.
	he Ho in 24 he Fu piefel	edical	one)	and manner st	f examination and/or ated.	investigation, in r	my opinion, deat	th occurred at th	e time, date	and place,	and due to	the cause(s)
١	To the within To the comple	Σ	29b. Signature and title of certifier	[\ \ \ \ \ .	A 4	29c. Lie	cense number		29d	_	ed (Month, E	
	7				~ ~ ~	7	D32261			Marc	h 30,	2005
Ľ	(6)		30. Name and addr s of person who can be a Pich		leath (Item 23a) (Typ an 9500 Ar		Rd T	anhom 1	MD 20	706		
	-04	•	Dr. Kich. 31. Date filed (Month, Day, Year)				Ku., L	amiaili, i	۷۵ کا	,,,,,,		
	Sta Registr		APR 0 4 2005	Blow	ar's Signature	A.						

Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 12936 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Betty Jean Whyte April 1 2005 /Medical 7:42 P 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Moran Manor Nursing Home Westernport
If Under 24 Hrs. 8. Date of If Under 1 Year 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sax **Funeral** Months Hours Days 1 ☐ M 2 ☑ F 72 Yrs. Director 6-14-1932 WV 232-48-1884 Usual Residence of Decedent pernit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Depertment of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Directo Clinton Township Mich. Macomb 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20043 Great Oaks Circle 48036 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education 12 School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lona Geiger Emory Whithrow 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lee Ann Cueva Niece 125 Summit Park Elkview, WV 25071 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-4-05 Westernport, MD Philos Cemetery 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Fredlock Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Or Seas pronany ens Examiner Due to (or as e consequence of): or Attending Physician: The lew requires that the death certificate be executed ettending physician and for use as the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 4 Stinknown 1 Yes 2 No 3 Probably Cerebro VASCULON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 NO 1 ☐ Yes 2 ☐ No 1 Yes certificete To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Thomicide 1/2 rtifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FROST BURE PL 503 10 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

2005

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** APRIL 2, 2005 MAURICE AARON WOLF 10:45 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND GARRETT 8. Date of Birth (Month, Day, Year FEB 10, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs 1927 213-22-3027 78 Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Meryland nent of Heelth and Mental Hygiene. nn: if Item 27 is marked other than "natural", or items 23s or 28s-f show 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County r items 23a or 28s-f show siner must be notified at 1 ☐ Yes 2 X No Director MD GARRETT OAKLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 DENNETT ROAD 21550 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 📉 No Specify: Specify: \$ WHITE 3 Widowed 4 Divorced WWII Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) GROCERY STORE MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALBERT LYDIA WONDERLY WALTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MONA I. WOLF - WIFE 419 DENNETT ROAD OAKLAND, MD 21550 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: if 4/5/05 4 ☐ Donation 5 ☐ Other (Specify) OAKLAND CEMETERY OAKLAND, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner use es the buriel-transit Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate hes been sit completely filled in by the funeral director, page 2 should I 24a. Was an autopsy performed? 1 Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1⊠Inpatient 2□ ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 1 X Naturel 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10+VA oak lara 30. Name and address of person who postpleted cause of death (Item 23a) (Type, Print) 21950 24/2/C1 31. Date filed (Month Pay Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	aryland /	Departmer Certificati			ind M	-	giene Reg. No:	105	1293	6
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	/Medio		4a. Facility Name (If not institution, Sacred He	give street and number)	sita	Cu	mb	Location o	and		4c. Cou	inty of Death		
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Baltimore,	permit, Pages Department of I Important: If it any injury or o		1 Durial 2 □ Cremation 1 □ Donation 5 □ Other (Sp. 21. Signature of Fineral Service L	ecify)	Turn	22. Name a Davi	nd Addres	s of Facility Burdo	ock I		Swanto		· Ω	
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P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deal	th 3 ⊟Ectopic p 5 ⊡ Other (s						Date of delive Month	ry Day Year	•
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			For State Registrar	State o	f Maryla		artment of tificate of				giene Reg. No.	05	12937
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	/Medic Examin		4a. Fecility Name (If not institut			ΙΤΑΙ.	4b. City, Town,		of Death			nty of Death	r
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year Months Day	r If Unde	Min.	B. Date of Birt (Month, Da	h		face (State or Foreign
	Director		220-28-7711	1 X M 2 □ F	71	Yrs.	Monard Bay	1.02.0			, 1933		
	and **	}	Usual Residence of Decedent 10a. State 10b. Cour	ntv	10c. C	ity, Town or Lo	cation		<u>_</u>			11	0d. Inside City Limits
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			For State Registrar	State of	Maryland /		artment rtificate			and M	-	giene Reg. No.	005	129	38
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Box 68760	death certificate be e attending physicii ed for use as the bu	in/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy	(7-1-		ANE	EGR.			2	23d. Date of	Morry	THE
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Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Li	G. Ww	ten								ON & S MD 212	ONS F.H., 17	IN
8760,	/Medical Examiner physician and physician the physician and the physician file physician and the physi	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entail the onlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence as a c	uence of):	ASI	A						Onset and Death	hs —
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy agge 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∏ Feta it at time of d	Ideath 3□	Ectopic pre						23d. Date of do Month	olivery Day Year	
s, P	quires that n signed b uld be deta	by	Part II. Other significant condition				nderlying ca	luse give	en in Part I.			obacco i Yes 2		to the cause of death? Probably 4 Unkno	
of Vital Record	The law requir ete has been si page 2 should I	Completed	MUTIPLE MY ESSENTIAL TO	1 ro KROCY	Tesis				- ·		24a. Was autop perfo		prior to death?		ble of
ita	ician: T certifical rector, p	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			2010	_
Ž	Physician: this certific al director,	5	1 ☐ Yes 2 🔀 No			ER/Outpatien			er: 4 □ Nu	rsing Hon	ne 5 Resi	dence	6 □Other (Sp	ecify)	
		lo I	27. Manner of Death 1 ⊠Natural 5 ☐ Pending		Injury Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe	now injur	y occurred		
Division	or:	ficat	2 Accident investiga 3 Suicide 6 Could no	t be	Inium - At ho	ome, farm, str	M eet factory		Yes 2□I	-	28f Location /	Street an	d Number or F	Rural Route Number,	
Ω	tal or Attendii s after death. al Director: A ed in by the fu	Certification;	4 Homicide determin		, etc. (Specif		oot, indicity	, omou			City or To			idia, i rocto riombor,	
	Hospit 4 hour Funera ely filk	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be reminer: On the bas and manne	is of examina	wledge, death tion and/or in	n occurred a vestigation,	at the tim in my op	ie, date and pinion, dea	d place, a	and due to the ad at the time,	cause(s) date and	and manner a d place, and du	as stated. ne to the cause(s)	
	To the within 2 To the complet	W	29b. Signature and title of certifier	011	a	1 1	29c	-	number	,			te signed (Mor		
	,		Mys	1 / ty	^	,)		00	82	46		i	4112	05	
	10		30. Name and add ss of person w	HEYN	MIN	and					,				
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 5	2005	istrar's Signa	Iture	book	,							

			For State Registrar		Maryland	d / Depa		t of H	ealth a	and M	•		nns		940
	Physici /Medic		Decedent's Name (First, Middle, NANCY		ANN		ASC				2. Date of De	12, Day		6:20	e of Death P M
	Examir	er	4a. Facility Name (If not institution, 3511 PHILIPS D	RIVE					BALT	IMOF				IMORE	
	Funeral Director		5. Social Security Number 213-60-3275 Usual Residence of Decedent	6. Sex 7	'. Age (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da SEP.24	1951	9. Birt	hplace (Sta untry)	te or Foreign
	tha Maryland 28a-f show notified at	rector	10a. State 10b. County	LTIMORE	10c. City	, Town or Lo		Code				10a Citiza	en of What Co	1 🗆 Y	e City Limits Yes 2 No
2-0030	within 72 hours aftar daath with tha Maryland ane. than "natural", or items 23a or 28a-f show he Medical Evante of must be invitited at	d by Funeral Director	3511 PHILIPS D 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 ADivorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	ces? 2∭X No		Vas Decec f Yes, spec	lent of Hi rify Cubar 2 XI No	Specify:		ecify Yes or No Rican, etc.)	5	4. Race - Ame Black, White Specify:	USA rican Indian e, etc. WHI	
7 7	iled within 72 i Hygiane. thar then "nat nt, the Medica	Completed	15. Decedant: (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L	College (1-	4or 5+)		dent's Usua kind of wor DO NOT us DNAL	k done d se retired; EXER	uring most	TRAI		EXE	RCISE/	,	SS
ryiand	hould ba f d Mantal h narked of natic eve	To Be	FREDERICK 19a. Informant's Name/Relationsh			WINNE	and the second named to the second		RIT	A RO	SENBER	G			
e, Mal	s 1 and 2 s if Haalth an itam 27 Is i othar traus		JANE BRONSTEIN 20a. Method of Disposition		20h Bl	7 OLI	CRO	WN C	OURT	- BA	al Route Numb LTIMOR Date	E, MD	21208		
baltimor	permit. Pagas Dapertmant of t Important: If its any injury or o		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	ecify)		22	OM M	EMOR d Addres	IAL 0	04/14 √ SOL	1/2005 L LEVIN ROAD -	R SON &		STOWN,	, MD
/oo,	Physician /Medical Examiner prize pr	icai Examiner	23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ch line.	Do not ent	er the mod	e of dying	, such as					Approximal Interval Onset a	
O. Box oa	death cartifics e attanding ph id for usa as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Yes		th 2 ☐ Fetal nt at time of de	death 3	Ectopic pro Other (sp					23	3d. Date of deli Month	ivery Day	Year
cords, r	w raquiras that tha bean signed by th should ba datacha	leted by P	Part II. Other significant condition	s contributing to dea	ath but not resu	Iting in the ur	nderlying ca	ause give	n in Part I.		23e. Did		e contribute to Øo 3□Pr		of death?
Ĭ,	The law ata has b page 2 st	Complet									24a. Was auto perfe 1 Yes		24b. Were au prior to death?	completion of	gs available of cause of
DIVISION OF VITAR	 Hoepital or Attanding Physician: The 24 hours after death. Funaral Diractor: Attar this cartificata lately filled in by the funeral director, pag 	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 3 Suicide 6 Could not determine	28a. Date of (Month	patient 2 E E Injury , Day Year) of Injury - At horg, etc. (Specify,	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	n 4□ Nu	rsing Ho	28d. Describe	idence 6 how injury		,	lumber,
	To the Hoepital or within 24 hours after To the Funaral Discomplately filled in	Medical C	29a. Certifier (Check only one) Check only 2 Medicel E	Physicien: To the baxeminer: On the baxeminer and manner	sis of examinati er stated.	ion and/or inv	estigation,	in my op	inion, dea	th occurr	red at the time,	date and p	place, and due	to the caus	
	0,		30. Name and address of person w	tho completed cause	of death (Item	23a) (Type	Print)	1	27	73	0	4	113/0	5	,
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signate	9 N	v. C	MAN	UT	jI	. B.	ATT	MUKE,	40	21204
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			For State Registrar	State o	of Maryla	nd / Depa <i>Cei</i>	artment rtificate			ınd M	ental H	ygiene Reg. Nø	2000		120	
I	Physici		Decedent's Name (First, Middle, L	ast)	Walla	200		B.c.	our l	00	2. Date of D Month	eath Day	y Ye	ar	3. Time of	
	/Medic Examir		John 4a. Facility Name (If not institution, g. SINAL HUSP	ive street and nu	mber)	TWOPE	40. OH		Location o	f Death	City	4c.	County of E	Death		- م
	Funeral Director		5. Social Security Number 6. 212-24-8246 Usual Residence of Decedent	Sex TV∏M 2□F	7. Age (In yrs 74	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.		Day, Year)	30	Birthpla Countr MI		or Foreign
	death with the Maryland ms 23a or 28a-f show in the notified at	ctor	10a. State 10b. County MD NA			altimo								10	d. Inside Ci	•
	with the a or 28	Dire	10e. Street and Number	_			10f. Zip			_		10g. Cit	izen of Wha			
920	hours after death w tural', or items 23a al Examinar nunt l	by Funeral Director	3202 Mondawmir 11. Marital Status 1 Never Married 2 Married 3 \textbf{X} Widowed 4 \textcolor Divorced}		2⊠No ive		Was Deced f Yes, spec	lent of Hi	21216 spanic Origin, Mexican Specify:		cify Yes or N Rican, etc.)	10-	U S 14. Race - A Black, V Specify:		n Indian, tc.	
Maryland 21215-0036	hin 72 an "ne Medic	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 10th grade			(Give	dent's Usua kind of wor DO NOT us Spat	rk done a se retired,	luring most	of working	ng		ind of Busin	ess/Indu	ustry	nors
nd 2	Hygi ther nt.	Be Co	17. Father's Name (First, Middle, Las				spac	CITE		r's Name	(First, Midd			ive	CTEC	mers
ryla		To	Rufus Brownlee			10b Maili	na Address	(Ctract o			Daws				2- 4-1	
	t and 2 Health a sm 27 is		Debbie Pringle 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	-Daugh	20b.		sper	anz	a Coi	urt,	Pik ate	esvi		Md	2120	8
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		*4 □Donation 5 □Other (Special Signature of Funeral Service Lice ■ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		Ced	Ma	. Name and	d Addres	s of Facility West	t	.6/05 Balt				e, Mc	
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on	caused the dealeach line.	ath. Do not ent		e of dying	g, such as					Í	Approximate nterval Bet Onset and I	e ween
8760,	rate be executed whysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Em Due to	O MSE (or as a conse	quence of):										
P.O. Box 687	The law requires that the death certificate te has been signed by the attending physionage 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregr birth 2 ☐ Fet nant at time of nown	tal death 3	Ectopic pro		*				23d. Date of Month			/ear
	equires that en signed b ould be deta	d by Pt	Part II. Other significant conditions	contributing to c	feath but not re	sulting in the u	ndertying ca	ause give	n in Part I.			tobacco u	use contribut □ No 3 □	te to the		eath?
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Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only				- n	18
of	ding After fune	atlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigati	28a. Date (Mor		ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 🗆 1401	2	ne 5 Re 28d. Describe			Specity)		
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	be d 28e. Place build	e of Injury - At I ling, etc. (Spec	home, farm, sti ify)	eet, factory	, office		2	28f. Location City or T	(Street an own, State		r Rural I	Route Num	ber,
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	X			distor	<u></u>	Sir	Print)	140	का क	91	of E	selt.	imer	e	Med	3
	Sta Regist	-	31. Date filed (Month, Day, Year) APR 15	2005	gistrar's Sign	nature	bede	,								

			110000	State of Maryland / Department of Health and	•	-	
			1 - For State Registrar	Certificate of Death	Reg.	711115	12942
	Physici	an	1. Decedent's Name (First, Middle, L	1645	2. Date of Death	Day Year	3. Time of Death
4	/Medic	al	4a. Facility Name (If not institution, or	Bowman A Site Town or Landing of S	April 7	2 2005	423 AM
	Examin	er	/ 4	ve street and number) 4b. City, Town, or Location of De	eath	4c. County of Death	•
	Funeral	7.	5. Social Security Number 6.	Sex 7. Age (In y.s. last birthday) If Under 1 Year If Under 24 Hours Months Days Hours M	irs. 8. Date of Birth (Month, Day, Ye	ar) 9 Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent	1 M 2AF 34 Yrs. Months Says Hours	3-22-	51 /40	wykus
	yland how		10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
	8a-f s	Director	MD	JA Baltimore			1 Yes 2 No
	with the or 2	Dire	1707 Lake	10f. Zip Code	10g.	Citizen of What Cou	intry?
	hours atter deeth with the Maryland tural, or tteme 23e or 28e-f show al Examinational be multipal at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Amer	ican Indian,
36	or ite	y Fui	1 Never Married Married	Armed Forces? 1 ☐ Yes 2 ☐ No Specify Cuban, Mexican, Pu 1 ☐ Yes Give 1 ☐ Yes 2 ☐ No Specify:	ierto Rican, etc.)	Black, White	, etc.
8	turai,	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	166	. Kind of Business/Ir	acto
21215-0036	d within 72 hours atter deeth with the Marylan jiene, Hen, "naturel", or iteme 23e or 28e-f show the Madical Esam incrinent be notified at	Completed	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) (Give kind of work done during most of work done during	working 1	1 .1 0	C
	filed with Hygiene other the		17. Father's Name (First, Middle, Las	4 years Self Employ	jed C	nila	Care
Maryland	ges 1 and 2 should be filed it of Health and Mental Hyg If Item 27 is marked othe or other treumatic event,	To Be	Ce orga A-m	Strad	Name (First, Middle, Maid	den Sumame)	
ary	shou and M smar	}	19a. Info ant Name/Relationship	(Type, Print Husham) 9b. Mailing Address (Street and Number or	Rur il Route Number, Cit	ty or Town, State, Zi	p Code)
- 10	and 2 ealth m 27 i		(el 1. Bon	smail 1707 (alesia	le Are L	Balto.M	1021318
Baltimore	Pages 1 nent of H int: if Ite		20a. Method of Disposition 1 Burial 2 Cremation 3 [Date 20c.	. Location - City or T	own, State
altin	artm orte inju		4 ☐ Donation 5 ☐ Other (Special21. Signature of Funeral Service Lice	The Winds Certainly	115/03 6	atimory	Services
ä	perm Depa impo any i		> leur M.	Sun 4905 youk	Load.	3° 14° V	1021212
			shock, or heart failure. List only	plications that caused the death. Do not enter the mode of dying such as card one cause on each line.	liac or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a freemonia			3 days
	Examiner			Due to (or as a consequence of):			
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
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1760	ate be executed hysician and the burial-transit	cal E		d			
89	rtificat ng ph) s as th		IF FEMALE:				
Вох	death certifica attending ph tor use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
P.0.	the de	Physiclan/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 5☐ Other (specify)9☐ Unknown			
	The law requires that the death certifica te has been signed by the attending ph bage 2 should be detached for use as the	by PI	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
ord	w requir been si should I				1 ☐ Yes	2 No 3 Pro	bably 4 dunknown
Records,	has b	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
		0	25. Was case referred to medical	26 Place of F	leath (Check only one)		22 No
Division of Vital	Physicien: rthis certitic ral director,	To B	examiner? 1 🗆 Yes 2 🗐 No	Hospital: Other	Home 5 Residence	6 ☐ Other (Speci	fy)
o u	ing PI		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how in	ijury occurred	
isio	Attend death ctor: , y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined.		28f. Location (Street	and Number or Rur	al Route Number
ā	tai or safter safter el Dire ed in b	Certification:	4 Homicide	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, St.		
	Hospi 4 hour Funer ely fills		(Check only 2 Medical Exa	nysician: To the best of my knowledge, death occurred at the time, date and pla miner: On the basis of examination and/or investigation, in my opinion, death oc	ice, and due to the cause	(s) and manner as a	stated, o the cause(s)
	To the Hospital or Attanding Physicien: within 24 hours after deals. To the Funerel Director: Attenthis certific completely filled in by the funeral director.	Medical	one) 29b. Signature and title of certifier	and manner stated. 29c. License number		Date signed (Month,	
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	10		1//		1001 71		100)
			31. Date filed (Month, Day, Year)	201 E University Parkway 2. Registrar's Signature	Baltimore	MU DIA	18
	Sta Registr	_	APR 1 5 200	15 Reduce to largeles			

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05-247	73		For State	State of Ma	aryland / Dep			lental Hyg	iene	NE	1201.2
AKG			Registrar	l and	Ce	rtificate of	Death		eg. No."	UJ	12340
	Physici	an	1. Decedent's Name (First, Middle, I	Woll R.	noth Gi	llard		2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,	nive street and number)	Hen -OI		or Location of Death	April 8	1	nty of Death	8:26 P ^m
	E Xaiiiii	iei	2538 Mosher Str			Baltimo				,	ALA
	. Funeral				e (In yrs. last birthday)			8. Date of Birth (Month, Day,	Year)	9. Birthpla	ace (State or Foreign
	Director		Usual Residence of Decedent	10 M 202F	57 Yrs.	/		12-12-	47	100	"(Y)D
	show		10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
	Man	ctor	WD	NIA		Bat	timore				1 Yes 2 □ No
	or 28	Director	10e. Street and Number	01		10f. Zip Code		1	0g. Citizen o	of What Count	ry?
	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or liems 23e or 28e-f show event, Tre Medical Exertinar must be rollined at	rai	2538 Mosher		F(: 110 110	\perp 20	46			154	
40	iter de	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		If Yes, specify Cabi	Hispanic Origin? (Spean, Mexican, Puerto	ecity Yes or No- Rican, etc.)		ace - America lack, White, e	
21215-0036	al', or	ğ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1☐ Yes 212 No	Specify:		Spe	oity: BIA	OK.
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup	during most of work	ina	16b. Kind of	Business/Indi	ustry
121	within ne. hen "	mpi	Elementary/Secondary (0·12)	Çellege (1-4or	5+)	DO NOT use retire			Mock	· unh	AL 18 A
Ö Ö	filed which the street		17. Father's Name (First, Middle, La	2 YRS.	1	chnician	18. Mother's Name	e (First, Middle, I	Maiden Sum	ame)	ouse
<u>a</u>	lid be lental rked c	To Be	Smithy 1.7	airne tit			Lucii () The	maso	Λ(
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show ther treumatic event, The Medical Evarities must be notified a		19a. Informant's ame/Relationship	(Type, Print)	19b. Mail	ng Address (Street	and Number of Rura	al Route Number	City or Tov	vn, State, Zip (Code)
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree <u>once</u> .		Karrisah +1	ytheldang	inter) 14 (!lematis	Court (Jums	Muls	mo	21117
ore	Pages 1 nent of H int: If ited iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	1 1 1 1	matory or other place	ce)	_	1	f - City or Tow	vn, State
Baltimore,	it. Pa rtmen rtent: njury		* 4 □ Donation 5 □ Other (Spe		Woodle		14-17			more	INO
Bal	permit. Departr Importe any inj		21. Signature of Funeral Service Lie	1 ×			ess of Facility			e fune	My sucs
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	d the death. Do not en	iter the mode of dyir	ng, such as cardiac				MD 21133
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	/Medical		disease or condition resulting in death)		a consequence of):	TOSCIELO	cic cardic	vascuta.	L UISE	ase	
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14	sit ad	Examiner	Sequentially list conditions, fary, lacong to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)						
4	be executed ician and buriat-transit	xar	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
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Вох	th cert endin r use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnanc	ev.			Date of deliver	•
	e deal	Sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant a 9☐ Unknown		Other (specify)	,			Month E	Day Year
P.O.	The law requires that the death certificate the has been signed by the attending physionage 2 should be detached for use as the the state of the sta		9 Unknown Part II. Other significant condition	s contributing to death t	out not resulting in the	inderlying cause an	ven in Part I	23e Did tol	nacco use ci	ontribute to the	cause of death?
Division of Vital Records,	signe d be	d by	,		and to the state of the state o	and any mig decided gre	VOI 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		s 2 No		11
Sor	w requir been si should	Completed						24a. Was a	n 24	h Were auton	sy findings available
Re	he la e has age 2	dmc						autops perforr	ned?	death?	sy findings available ipletion of cause of
ta	en: T tifficat tor, pa	e e	25. Was case referred to medical		<u> </u>		26. Place of Deat		2 No	1 Yes 2	2 No
<u>></u>	Physicien: this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	nt 3 DOA	her	me 5 🗆 Reside		Sther (Specify)	at scene
0	ing Pl		27. Manner of Death 122 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time (lay Year) Injury	Wo	rk?	28d. Describe ho	ow injury occ	urred	
Sio	tendi Jeath. tor: A the fu	Certification:	2 Accident investiga 3 Suicide 6 Could no				Yes 2 □ No	006 1			
Οİ	or Atter of Direction by	ertifi	4 Homicide determin	ed 28e. Place of In building, e	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Nu n, State)	m <i>ber or Rurai</i>	Route Number,
	spitel		29a. Certifier 1 ☐ Certifying	Physician: To the best	of my knowledge, dea	th occurred at the tir	ime, date and place.	and due to the c	ause(s) and	manner as sta	ited.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical		caminer: On the basis of and manner st	of examination and/or in	nvestigation, in my d	opinion, death occur	red at the time, d	ate and plac	e, and due to	the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	<u> </u>	O .	29c. Licens	se number	2	9d. Date sig	ned (Month, D	Pay, Year)
	-	1	Vatille on	un- toll	Jeh no	0.C.N	M.E.		Apri1	9, 200	5
	1/2		30. Name and address of person w	ho completed cause of	1)	,			*		
90			31. Date filed (Month, Day, Year)	N. CA - 10	I AK W 11	1 Penn St	treet, Bal	Ltimore,	Maryl	and 2	1201
	Sta Regist	ate rar	APR 1		8.4	books					

with the Maryland filed within 72 hours after death Baltimore, Maryland 21215-0036

Physician Examiner use as the burial-transit

The law requires that the death certificate be executed signed by the attending physician and this certificate After

Division of Vital Records, P.O. Box 68760, or Attending Physician:

Please Type or Print in-Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10b c.e. f per inf 9843 5-19-05 yt.

State of Maryland & Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 **Physician** April 5, Year 01ive Young Brown 11:40 PMM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pickett Gill Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
July 2, 1911 9. Birthplace (State or Foreign Bruchsh Columbia **Funeral** 1 ☐ M 2 ☐ F Director 072-12-0400 93 Usual Residence of Decedent 10a. State 10b. Ar Trington 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-1 show the Medical Examinar must be notified at Arlington VA Loudoun 1 ☐ Yes 2 ☐ No Director Purcellville 10e. Street and Number 814 26th Pl. South 10f. Zip Code 22202 10g. Citizen of What Country? 19520 Lincoln Road 20132 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dietitian 5+ Health Care permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth-any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert MacBeath Young Frances Ferguson Wilmot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Gael McPherson Post 815 Loyola Drive Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Friend's Cemetery Lincoln, VA 4 ☐ Donation 5 ☐ Other (Specify) 4-16-05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hall Funeral Home P.O. Box 896 Purcellville, Virginia 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) pheral Vaseular disease /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient Certification: To 3∏ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pendirig investigation 1 Yes 2 No after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 25205 uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. 31. Date filed (Month, Day, Year) APR 1 5 2005 32. Rg State Registrar

DHMH 17 Rev 1/2001

			1 - For State of Maryland / Dep	artment of Health and Martificate of Death	-	ene2005	12946
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Media	al		lackmon	April	09, 2005	
4	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	ith
	Funeral		Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore If Under 1 Year If Under 24 Hrs.	8. Oate of Birth		tholace (State or Foreign
	Director		220-76-0540 1\XIM 2□F 31 Yrs.	Months Days Hours Min.	(Month, Day, Oct. 3,	Year) C 1973 M	thplace (State or Foreign ountry) aryland
	pu ,		Usual Residence of Decedent				
	death with the Maryland me 23a or 28a-f show trrust be notified at	5	10a. State 10b. County 10c. City, Town or L Maryland Baltimore	Baltimore			10d. Inside City Limits
	28a-f	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What C	
	with Sa or			2122		United S	
	death w	Funerai	7022 Eastern Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.			14. Race - Am	
Maryland 21215-0036	72 hours after of netural, or Iter dical Examiner	þ	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, Whi	te, etc. White
2-0	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation a kind of work done during most of worki	100	6b. Kind of Business	
2	c *_ @	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	ng		
21	be filed withi tal Hyglene. d other then event, the M	Cor		es Consultant		Automotiv	e
and	should be filed wind Mental Hygle marked other umatic event.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
Z,	should nd Men marke umatic	P P	Edward L. Blackmon, Sr. 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mail			T. Scott	7.0.11
Ma	d 2 s th an th an traur			ing Address <i>(Str</i> eet a <i>nd Number or Rura</i> 2 Eastern Ave. Ba		Maryland	2122 4
ē,	es 1 and 2 should bot Health and Ment [Item 27 is marked rother traumatics]		20a. Method of Disposition 20b. Place of Disp	osition (Name of		0c. Location - City or	Town, State
J.	Pages nent of int: if it		145 Buttat 5 Clettuation 2 Premovat from State	matory or other place) Cemetery 4/15/20	05	Raltimore	, Maryland
Baltimore,	permit. Pages 'Department of H important: If Ite any injury or of		21. Signature & Funeral Service Licensee	2. Name and Address of Facility Duda-Ruck Funeral	Home of	Dundalk, i	Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	7922 Wise Ave. Du ter the mode of dying, such as cardiac of			21222 Approximate
	Physician		Immediate Cause (Einal				Interval Between Onset and Death
4	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	1014005			
	Examiner		Sequentially list conditions b.				
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed icien and burial-transit	Examiner	that initiated events				
8760,	sate be ex hysicien the burial		Due to (or as a consequence of):				
687	phys phys s the	dicai	d				
Box (requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	liven
B	death s atter	iciai	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.0	that the d ad by the detached	hys	9 ☐ Unknown				<u></u>
	res tha igned I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	w require been si should t	ed			1 ☐ Yes	: 2 No 3 □ P	robably 4 Unknown
Vital Records,	aw ls b	Completed			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
= E	Th ate pag	Con			performe	ed? death? □No 1 □ Yes	
/ita	vsician: Th	Be	25. Was case referred to medical examiner?	26. Place of Death	Check onl- one		
of	hys this al dii	은	1X Yes 2 No Hospital: 1 Inpatient 2 X ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of			ce 6 □Other (Spe	cify)
Division of	ng ifter inei	ion	1 Natural 5 Pending (Month, Day Year) Injury	Work?	28d. Describe how		CAL
Si	Attending r death. sctor: After y the fune	Ical	2 Saccident investigation 3 Suicide 6 Could not be			eet and Number or Ri	IMPOUT ICITIL
Div	after after Dire	Certification:	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town,	State)	
	To the Hoepitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dear	h occurred at the time, date and place a	and due to the cau	ise(s) and manner as	STATE BALLET
	n 24 l	edicai	(Check only one) 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
	To the To the comp	2	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Mont	h, Day, Year)
			Mounte Brethile M	O.C.M.E.	An	ril 10, 20	005
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	•		
10	27			n Street, Baltimor	e, Maryl	and 21201	
	Sta Registr	4	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sperle			
	negisti	all	APR 1 5 2005 Mesers 15.				

			Please	Type or Print in State of Mary	land / Dep	artment of	Health and	-		_	1201-
			Registrar 1. Decedent's Name (First, Middle, La	st)	Ce	rtificate of	Death	2 Date	Reg.	No. UUU	12941
	Physici		JAMES	BUTTE	REIEI	\cap		Mont	h ,	Day Year	3. Time of Death 5 2:38AM
	/Medic Examir		4a. Facility Name (If not institution, give		ATT TEE		or Location of De			4c. County of Dea	
			GOOD SAMAR	TAN HOSE	TAL	BALT	IMORE			N/A	
	Funeral Director		219-07-1127	7. Age (In	yrs. last birthday Yrs.	Months Days		in. B. Date (Mont	of Birth th, Day, Ye 1, 1	9. Bin 921 Mar	thplace (State or Foreign ountry) yland
	aryland show	-	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation					10d. Inside City Limits
	Ne Me	Directo	Maryland N/A		Baltim						1∭Yes 2∏No
	with t	Dir	10e. Street and Number 1527 Ralworth Ro	hod		10f. Zip Code	21218		10g.	Citizen of What C	ountry?
	death ms 23	Funerai	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of If Yes, specify Cub		(Specify Yes	or No-	U.S.A.	erican Indian,
030	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-1 show its Medical Exemirer must be rodified at	by	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW		If Yes, specify Cub 1 ☐ Yes 2 X No		erto Rican, et	c.)	Black, Whi	
212-0036	d within 72 ho piene. r then "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of v	vorking	16b	. Kind of Business	
V	filed wit Hygiene other the	Com	12 years			Drafts	man			Federal	Government
and	o or and	Be	17. Father's Name (First, Middle, Last				18. Mother's N			den Sumame)	
Ξ	2 should be and Menta Is marked eumatic ev	2	James K. Butter 19a. Informant's Name/Relationship (10b Maili	na Addrona (Street		ed J. D			7: 0-11
e, Mal	1 and 1ealth em 27 ther tr		J. Alan Butterfie	ld (son)	110	ng Address (Street			ore.	Marylan. Location - City or	21218
бащтог			1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cre	matory or other pla prest Veter	1	4-15-05			s, Maryland
pall	permit. Pege Department of Importent: if any injury or once.		21. Signature of Funeral Service Licer	nane	M	2. Name and Addre 1itchell – 500 York	Wiedefel Road	ld Fune	ral H	lome, Inc	21212
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the cone cause on each line. a	SIS	ter the mode of dyi	ng, such as card	iac or respirat	ory arrest,	<i>,</i>	21212 Approximate Interval Between Onset and Death
00/00,	ate be executed sysician and he burial-transit	ical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con c. Due to (or as a con d.							
O. BOX og	the death certificate be ev y the attending physician ched for use as the buria	hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[□Ectopic pregnanc	у			23d. Date of de Month	ivery Day Year
7.	w requires that the de been signed by the should be detached	Д.	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e.	Did tobacc	o use contribute to	the cause of death?
colds	quire an sig uld b	ed b	RUPTURED ABOU	DHINAL AOF	CTIC AN	JEURYSI	4	. 111	1 🗌 Yes	2 □ No 3 □ Pr	obably 4 donknown
ב ב	ulcian: The law requires that the certificate has been signed by th rector, page 2 should be detache	ompieted by							Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Z Z	ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of D		res 221	¶o 1 ☐ Yes	2L No
> 5	Physician: rthis certific ral director,	ပ	1□Yes 22No		2 ER/Outpatier	IL 3 DOA				6 □Other (Spe	cify)
DIVISION	fter fter	ertification;	27. Manner of Death Natural 5 Pending 2 Accident investigation		r) 28b. Time o	Wo	ryat rk?]Yes 2 □ No	28d. Desc	ribe how in	jury occurred	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, str ecify)	reet, factory, office		28f. Locati City o	ion (Street r Town, Sta	and Number or Ru ate)	ral Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier 12 Certifying Ph (Check only one) 2 Medicel Exen	ysicien: To the best of my niner: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ce, and due to curred at the t	the cause ime, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To t To ti	Ž	29b. Signature and title of certifier	2		29c. Licens				Date signed (Monti	**
	X		1 6 Boyayak	y, M.D			306			04/13/2	
9	5		30. Name and address o pe	pleted cause of death (Item 23a) (Type,	Print) Goo	DSAMA	IRITAI	V HW	SPITAL	-
	, Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	CH KAU	EN BLI	IP, BA	LTIM	ORE, M	DZ1239
	Registr	4.	APR 1 5 20	RJEILY/S 32 Aegistrar's S	IF AS	West !					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Hanson Bover 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth

7. Age (In yrs. last birthday)

Yrs.

10c. City, Town or Location

Bel Air

Bel Air

10f. Zip Code

1 ☐ Yes 2 No

1112 Moores Mill

Owner & Operator

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

21014

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Louise

535256C

MOLINA-1

1620 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Mary Land

Harford

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

White

Real Estate Developer

Nelson

Approximate Interval Between Onset and Death

Day

USA

Specify.

18. Mother's Name (First, Middle, Maiden Sumame)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

(unk)

Road, Bel Air, Maryland 21014

16b. Kind of Business/Industry

1926

Physician /Medical Examiner

Funeral Director

item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be inclined at

Baltimore, Maryland 21215-0036

Enysician /Medical Examiner

P.O. Vital Division within 24 ho To the Fune completely fi

Box

Records.

of

Physician/Medical Certification: To

Upper Chesapeake Medical Center 217-20-7028
Usual Residence of Decedent 10a. State 10b. County Directo Maryland Harford 10e. Street and Number 1112 Moores Mill Road by Funeral 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Oliver 19a. Informant's Name/Relationship (Type, Print) Patricia G. Boyer - Wife 20a. Method of Disposition IF FEMALE:

Henry

6. Sex

Porter

1**X**M 2□F

12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: WW II

Bover

College (1-4or 5+)

Natural 2 Accident 3 ☐ Suicide 4 Homicide Medical 29a. Certifier (Check only one)

State Registrar

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 4/11/05 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 / Decons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) respect Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

615 w.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SDULL

ov, D

APR 1 5 2005

31. Date filed (Month, Day, Year)

			For State Registrar	State of	Marylar			of Heal		Mental Hy	giene Reg. No.	2000	120	1.0
U	District Control		1. Decedent's Name (First, Middle	, Last)						2. Date of Dea			3. Time of D	eath
	Physici /Medio		Carolyn		Belo	cher					7, 2	2005 Year	19:00	М
	Examir	ner	4a. Facility Name (If not institution	, give street and nun	nber)			Town, or Loca	ation of Death	1	4c.	County of Death		
			3460 Albantowne		7 Ann //	In ma thringh at 11.	Edc If Under	jewood	Indos 94 Uso	T		Harford		
	Funeral Director		5. Social Security Number 183-36-5303 Usual Residence of Decedent	6. Sex 1 ☐ M 2/2/ F	7. Age (In yrs.	56 Yrs.	Months		Inder 24 Hrs. ours Min.	8. Date of Birti (Month, Day July 1	, Year)	9. Birthi Cou 1948 Peni	olace (State or i ntry) nsylvan	Foreign ia
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City	Limits
	Many Fed	to	Maryland Harfo	ord		Edgew	Σ						1 ☐ Yes 🤅	No 🕽
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f ahow or other than "natural", or items 24a or 28a-f ahow event, the Modical Event instruments in chilled at	Funeral Director	10e. Street and Number			Dagom	10f. Zip	Code			10g. Citi	zen of What Cou	ntry?	
	th wi	ai	3460 Albantowne	e Way			21	1040			Ţ	JSA		
	ems ems	nei	11. Marital Status	12. Was Dece Armed For	dent Ever in U	I.S. 13.	Was Deced	ent of Hispani fv Cuban. Me	ic Origin? (Se	pecify Yes or No- o Rican, etc.)		14. Race - Americ Black, White,		
36	or II	by Fu	1 Never Married 2 Marr	If Yes, Giv	θ	ĺ	1□Yes 2		ecify:			Specify:	elc.	
5-0036	hour tural	d be	3 ☐ Widowed 4 ☑ Divorced	Year or Da	ites:						15: 15	BLa	ack	_
5	in 72	Completed	15. Decedent (Specify only highes	t grade completed)		(Give	kind of wor DO NOT us	l Occupation k done during e retired)	most of wor	king		nd of Business/In	dustry	
121	should be filed within a Mental Hygiene. marked other than matte event, the Matter event, the Mental contents and the matter event, the Mental contents and the Mental content	mo	Elementary/Secondary (0-12)	College (1	-4or 5+)			ative A	\ccic+:	ant		ollege scation		
<u>0</u>	Hygid other ent, I	Be C	17. Father's Name (First, Middle,	Last)		1 Addition	ILSCIC			ne (First, Middle,				
au	ould be Mental arked o	To B	Joe (nmn)	Simmons				Ev	ælyn	(nmr	1)	Harmon	n	
Maryland 2		-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address		_ -		·	r Town, State, Zip		
	1 and 2 Health a tem 27 is	18	Walter C. Belch	er. Jr	Son	3460	Albar	towne	Way, I	Edgewood	. Ma	ryland 2	21040	
Itimore,		J 8	20a. Method of Disposition 1 Burial 2 □ Cremation	•	20b. F	Place of Disponentery, crea	sition (Nam	e of		Date	•	cation - City or To		
Ĕ		ļ.,	`4 □Donation 5 □ Other (S)		Hi	ghview	Mem.	Gardens	s 4-1	3-2005	Fal:	lston, M	D	
a	permit. Pag Department Important: I any injury o	r I	21. Signature of Funeral Service	icensee	/	22	2. Name and	d Address of F	Facility 1	AcComas :	Fun∈	eral Home	e, P.A.	
<u>m</u>	972 = 9	2 1	Stepley a	Much								ı, Maryla	and 210	09
ł	Physician /Medical Examiner	ek T	23a. Paft 1. Efter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aDue to	y Character deal	ulici quence of):	Leve the mode	i brace	chas cardiac chion	diseed			Approximate Interval Betwee Onset and De	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of as a consequence	quence of):	Me	l.fus					5 yeer	~£.
.O. Box 6	res that the death certific signed by the attending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nth 2 ☐ Feta ant at time of c	al death 3[∃Ectopic pre ∃ Other <i>(sp</i> e				2	23d. Date of delive Month	ery Day Ye	ar
o.	s that ned b	by P	Part II. Other significant condition	ns contributing to de	ath but not res	sulting in the u	nderlying ca	use given in f	Part I.	23e. Did to	bacco u	se contribute to t	ne cause of dea	ith?
rds	w require been sig should b	ed t	Hyperters	ion						1 X Y	es 2[□No 3 □ Prob	ably 4 🗆 Uni	known
Records,	Physician: The law requires that the this certificate has been signed by th al director, page 2 should be delache	Completed	Hypechile	skelem	·a					24a. Was a autop perfor	sy	death?	psy findings av mpletion of cau	ailable ise of
Viital	rtifica ctor, p	e e	25. Was case referred to medical					26. 1	Place of Dea	1 ☐ Yes th (Check only or		1 1 1 1 1 1 1 1	2010	
	Physician: r this certificatal director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 II	npatient 2	ER/Outpatier	nt 3 DO	Other	☐ Nursing H	1		Other (Specif	(y)	
o c			27. Manner of Death 1) Natural 5 Pendin	28a. Date of	of Injury h, Day Year)	28b. Time o	f 28	3c. Injury at Work?		28d. Describe h			,,	
0	Attendir death. ctor: Af y the fu	atlc	2 Accident investig	ation		,,,,,,	М	1 Tes	2 🗆 No					
Division	tal or Atteners after death	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 289. Place	of Injury - At h ng, etc. (Specif		reet, factory,	office		28f. Location (S City or Tow	treet and n, State)	d Number or Rura)	l Route Numbe	er,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	29a. Certifier // Certifyin (Check only one)	g Physician: To the Examiner: On the ba and mann	isis ot examina	owledge, deat ation and/or in	h occurred a vestigation,	it the time, da in my opinion	te and place, , death occur	and due to the orred at the time, o	ause(s) late and	and manner as s place, and due to	tated. the cause(s)	
	To t withi To tl	ž	29b. Signature and title of Control	< /			29c.	License num	ber	2	9d. Date	e signed (Month,	Day, Year)	
	<u> </u>		1//)(s	DO F	nof	1	+390	550	1	Ipa	ILK	7005	5
	10	1	30. Name and address of person	who completed caus	of death (Iter	п 23а) (Туре,	Print)	, 1	1,	5/	11.12	di		
			31. Date filed (Month, Day, Year)	STZ 13E	8 5 egistrar's Signa	usines	5 Ces	Her /	Vas	Kdeer	ud	Mode	1048)
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DHMH 17 Rev 1/2001

		1	1 - For State Registrar	State of M	laryland	/ Depa		t of H	ealth a	and M	•		-20	05	12	951
			1. Decedent's Name (First, Middle, Las	t)							2, Date of i		Day	Voor	3. Time	of Death
	Physicia /Medic		Janice	S.	Bro	wn					April	12,	2005	Year	2:15	A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death			4c. County		1	
		•	Glen Meadows Reti	rement Co	mmunit	y		n Ar					E	Balt	more	
1	Funeral		Social Security Number 6. Security Number		ge (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of 8 (Month,	Day, Yea	ar)	9. Birth	place (State untry)	or Foreign
	Director		012-22-2539	□ M 2 💢 F	82	Yrs.					July	17,1	922	Oł	nió	
	pu .	1	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	veation								10d. Inside	City Limits
	sho	7														s 2X No
	Me M	Director	Maryland Baltimor	e		<u>Glen</u>		-				10	mint 6.6			74
	vith ti	급	10e. Street and Number				10f. Zip					_	Citizen of \		intry?	
	ath v	<u>ra</u>	11630 Glen Arm Ro			1.0		057					U.S.A			
	er de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Sp i, Puerto	ecify Yes or I Rican, etc.)	NO-		e - Amer ck, White	ican Indian, , etc.	
36	be filed within 72 hours after death with the Maryland ital tytgiene. od other than "neturel", or Items 23e or 28e-f show event, I'le Medical Exam or must be notified at	γF	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 💢 If Yes, Give Year or Dates			1□ Yes	2 □ X √10	Specify:				Specify	/: L	hite	
Ş	hour turel	Completed by	15. Decedent's Ed			16a Dece	dent's Usua	LOccupa	ition			16h	Kind of B			
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a	d be antal ced o	To Be	Clinton D.	St. Clai	٣				Max	rgare	o.t	Glen	n			
2	2 should be and Mental is marked eumatic ev	Ĕ	19a. Informant's Name/Relationship (7			19b. Maili	ng Address	(Street a			a <i>l R</i> oute Nun			State, Z	ip Code)	
Maryland 21215-0036	ges 1 and 2 should it of Health and Mer if item 27 is marke or other treumatic		Charles F. Brown,				Glen								yland	2105
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õ	Pages nent of ant: If it ury or o		1 ☐ Burial 2 🎇 Cremation 3 🗆		9		matory or o			1 1 1	2005					
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Ba	permit. Pages Department of Importent: If i any injury or o						1050			y Kuc	ck Tow Towson	son	runer	al F	ome, 21204	inc.
			23a. Part1. Enter the disease, or comp	plidations that cause	ad the death	Do not en							ryiai	lu	Approxim	ate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aAL	line.			1			NTI				Interval B Onset and	etween
	/Medical Examiner		resulting in death)	Dua to (or a	s a conseque	nce of):									,	
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Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth	2 Fetal de	eath 3	Ectopic pr							te of deli inth	very Day	Year
0	e de the a	/slc	1 ☐ Yes 2 No 9 ☐ Unknown	4□ Pregnant : 9□ Unknown	at time of dear	th 5L	Other (sp	ecify)							,	
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	The ate h page	Son									1 ☐ Yes	rformed? 2 2 2	Vo !	death? 1 🗌 Yes	2 No	
Vital	Physicien: The lithis certificate har all director, page	Be (25. Was case referred to medical examiner?						26. Place	of Deat	h (Check onl	у опе)				
	Physic this ce al dire	ပို	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat	tient 2 EF	NOutpatie	nt 3 DO	A Othe	r: 4 Nu	rsing Ho	me 5 Re	sidence	6 □Oth	er (Spec	ify)	
Division of	or Attending Ph ifter death. Director: After th in by the funeral	:u	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 21 lay Year)	8b. Time o	f 2	8c. Injury Work	at ?		28d. Describ	e how in	jury occur	red		
Ö	Attending ir death. ector: After by the funer	atle	2 Accident investigation				М	1 🗆 ነ	fes 2□	No						
N	or Attendate death Director: In by the	tifle	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of II	njury - At hometc. (Specify)	e, farm, st	eet, factory	, office			28f. Location City or 1			er or Ru	ral Route Nu	ımber,
	s aft al Di	Certification;		3.	(=,,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,											
	To the Hospitel or A within 24 hours after To the Funeral Direction Completely filled in by	edical	(Check only 2 Medical Exam	ysician: To the bes												e(s)
	the l	Med	one)	and manner s	stated.		100					001 5		1 /4 /	0	
	To with	2	29b. Signature and title of certifier			60	290		number	- 0		29d. L	ate signe	d (Month	Day, Year)	
ŧ				KLOPA	De la	119	_f	5	12:	25		_ 4	113	12	007	
	(1		30. Name and address of person who	completed cause of	death (Item 2	За) (Туре,	Print)	1.	70	. 00	a teleri	2.	70.	î.	100	030
_	8) LIIN	44	4020 P	2.0 円	1, 1,12d	DAG	1'm0/	5 E 11	ツスリ	1-48
	Sta		31. Date filed (Month, Day, Year)	32. Pagis	trar's Signatur	re		turning.								
	Registr	ar	APR 152	UUD See	we l	7 1	medi	•								
DH	- HMH 17 Rev 1/2	001	-			3	232									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician BURLEY MICHAEL 8:05 AM 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth 10-02-1941 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday **Funeral** Days Hours Min Months 64 215-40-8102 Director Maryland Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Nedical Examiner must be notified at 1XXYes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21215 6527 Eberle Drive Apt 201 permit. Pages 1 and 2 should be filed within 72 hours alter death v Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, tra Medical Exercises PARE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Nivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Plant 8 Chemical Tech. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mable Osbourne Foster Burley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn O. Brice/ Daughter 6527 Eberle Drive Apt 201 Baltimore,MD 21215 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Randallstown, MD 04-16-05 King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Baltimore, MD reneila 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death cartificate be axecuted that initiated events and resulting in death) Last Due to (or as a consequence of): fF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year page 2 should be detached for in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9. Unknown ting to death but not result 23e. Did tobacco use contribute to the cause of death? gnificant conditions contrib g in the underlying cause given in Part I. Division of Vital Records. 1 Yes 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes

funeral director, the in by

Box 68760.

P.0

B

Be Completed by Physician/Medical Certification: To

5

25. Was case referred to medical 2 No 1 Yes 27. Manner of Death

Naturaf 2 Accident 5 Pending investigation 3 ☐ Suicide

6 Could not be 4 Homicide

Hospital: 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

and manner stated

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

28c. injury at Work? 1 Yes 2 No

Other:

26. Place of Death (Check only of

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifie

(Check only

29c. License number

29d, Date signed (Month, Day, Year)

State Registrar

s after death.

within 24 hours a

To the Funeral Completely filled

To the !

Medical

			1 - State of Maryland / Dep Registrer Ce	artment of Health and Martificate of Death		ene 2 () () 5 g. No.	12952
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Genevieve A. Camarata	T., 2, 2	April	12, 2005	3:55 P M
2.5	Examin	er	4a. Facility Name (If not institution, give street and number) Quail Run Elder Care Community	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs.		4c. County of Dear	more
	Funeral Director		5. Social Security Number 216-28-1883 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth Month Day, April 8,	1915 Ma	hplace (State or Foreign buntry) TYLANd
	nand ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Many a-f sh	tor	Maryland Baltimore	Perry Hall			1 ☐ Yes 2 No
	or 284	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	
	ath w		4915 Forge Road	21128		u.s.	
980	hours after death with the Maryland tural', or Items 23s or 28a-f show al Ers cinet must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 William Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
5-0	72 hours "natural",	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	kina 1	6b. Kind of Business	Industry
2	d within 72 ho jiene. r than "natur Ine medical	nple.	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		Own Home	
2	illed will Hygie other ti		7th Grade 17. Father's Name (First, Middle, Last)	Homemaker 18 Mother's Nam	ne (First, Middle, M		
Maryland 21215-0036	Q 6 0 9	To Be	Frank Morawski	Maryan	n Sobe	ecka	
Mai	C1 ·= 63			ing Address (Street and Number or Rui Hards crabble Road			2918
	1 and Health tem 27 other tr		20a. Method of Disposition 20b. Place of Disp	osition (Name of		Oc. Location - City or	
υ	Pages nent of int: If it		1 Burial 2 Cremation 3 Removal from State commetery, cre 4 Donation 5 Other (Specify) Entombment Dulancy	Walley Maus 4/1	5/2005 1	Timonium,	Maruland
Baltimore,	permit. Pages Department of h Important: If ite any injury or of				chimunek	Funeral H	omes
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	BRIERY	15CA	25	
	Examiner		CHRONIL OF	STRUCTIVE	Pulm	MARY	
	Described in	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		DEEP.	75E	
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	SIZN			
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8760,	physi	dice	d. P1/10 /11 9 /20	11)00			
Box 6	eath certif attending for use a	hysician/Medical	1 Ves 3 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
P.0	that the di ed by the detached	Phys	9 Unknown				
Vital Records, I	v requires that been signed should be de	by	Part II. Other significant conditions contributing to death but not resulting in the to	Inderlying cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pr	
၀	N S C	Completed			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
H.	0 5 0	m o			perform	ed? death? □ 1 □ Yes	
İta	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	26. Place of Dear	th (Check only one		
of V	Physician: this certific ral director,	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ome 5 Resider		cify)
	ing After une	lon:	27. Mann of Death 1 Leatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	v injury occurred	
Division	Attending is death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st		28f. Location (Stre	eet and Number or Ru	ural Route Number.
Di	S Sir fe	Certification:	4 Homicide determined building, etc. (Specify)	root, lactory, office	City or Town,	State)	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, ivestigation, in my opinion, death occur	, and due to the car rred at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
	ro the	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Monti	/ -
	- 2 - 0		Solicin deal (Shore MD)	カクフノを	8	4/15/	35
•	1/2		30 Name and address of person who completed cause of death (Item 23a) (Type	127/89 14- 16 (0)	2000	ale. N	10 21 >22
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4 16 4	cara	enu "	
	Registr		APR 1 5 2005 Beacus -	is again			

			1 - For State Registrar	State of Maryla	and / Depa		alth and M	lental Hyg	9	5 12953
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Las James Carroll Ca 4a. Facility Name (If not institution, give	vanaugh		4b. City, Town, or Lo	cation of Death	2. Date of Deat Month APRIL	Day Year 14 200 4c. County of Day	5 0140 AM
	Funeral Director		Union Memorial F 5. Social Security Number 213-14-5808 Usual Residence of Decedent		rs. last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 23	n/a year) 9. E 1920 M	Birthplace (State or Foreign Country) aryland
	the Maryland 28e-f show notified at	Director	10a. State 10b. County Md. Harford 10e. Street and Number		City, Town or Lo	Bel Air		11	Dg. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 No
36	d within 72 hours after death with the Maryland jiene. r then "neturel", or Items 23e or 28e-f show the Medical Executer Frast be in diffied at	by Funerai Di	1118-A Spalding 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Drive 12. Was Decedent Ever in Amed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		21014 Was Decedent of Hispa If Yes, specify Cuban, N			U.S.A.	merican Indian, hite, etc.
Maryland 21215-0036	力をとき	Completed	(Specify only highest gra	de completed) College (1-4or 5+)		dent's Usual Occupation kind of work done during DO NOT use retired) 1 worker			16b. Kind of Busine	ss/Industry
ryland	d ta b	To Be	17. Father's Name (First, Middle, Last) Patrick A. Caval 19a. Informant's Name/Relationship (1)	naugh	19h Mailir		Anna Jo	e (First, Middle, M sephine	Sweeney	a Zin Code)
Baltimore, Ma	Pages 1 and 2 nent of Health a sut: If item 27 Is ury or other tre	1	Cheryl Chizmar/ 20a. Method of Disposition 1 Burial 2 Cremation 3 Chief Company 4 Donation 5 Other (Specify	daughter 20th Removal from State mausoleum H	1512 D. Place of Dispo cemetery, crer Bel Air	Parkland sition (Name of natory or other place) Mem. Gdns.	Drive, 4/16	Bel Air, Date / 2005	MD 21015 20c. Location City Bel Air,	or Town, State
Bal	permit. Departr Importe eny inju		21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or compensors, or heart failure. List only	111	6	Name and Address of Chimunek F 10 W. MacP er the mode of dying, s	hail Ro	ad, Bel	Air, MD 2	21014 Approximate
760, 10	/Medical Examiner	cai Examiner	snock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		YSPLAST sequence of):	ic syndr				Interval Between Onset and Death NINE DAYS
.O. Box 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as It	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F: 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
Д.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not r	resulting in the u	nderlying cause given it	n Part I.			to the cause of death? Probably 4 □Unknown
Vital Records,		Completed						24a. Was ar autopsy perform 1 Yes 2	prior t	
of	Attending Physicien: 1 r death. ector: After this certifical by the funeral director, p	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Minpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of	ot 3 DOA Other: 28c. Injury at Work?	4 Nursing Ho	me 5 ☐ Reside 28d. Describe ho	nce 6 Other (S)	pecify)
Division	i di te	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Spe	ecity)			City or Town	, State)	Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledicai	one)	ysician: To the best of my k niner: On the basis of exam and manner stated.	knowledge, death ination and/or in	vestigation, in my opinio	on, death occurr	ed at the time, da	te and place, and d	ue to the cause(s)
)	1	Σ	29b. Signature and title of certifier	al MD		29c. License nu AT 2438	3946-E	37 A	PRIL IH	
	1/2		30. Name and address of person who of PARUL AGARWAL, I 31. Date filed (Month, Day, Year)	completed cause of death (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	tem 23a) (Type, UNIVERS	Print) PARKWAY	BALTIM	ORE, MD	21218	
	Sta Registr		31. Date filed (Month, Day, Year)	PR 1 5 2005	The same	13 PM				

DHMH 17 Rev 1/2001

			Amend items 16a 1- State Registrar	e Type or Print b per fh. am n 16a per in	in Black In end items vland Depa f 8854	delible Ink. 23c e pe artment of H	Ensure A r phys glealth and N	II Copies 842 4 –28 Iental Hy	Are Lee 8-05 vi	gible.	
	انما	Ш	Hegistrar 1. Decedent's Name (First, Middle,		001	timeate of L	Jeani	2. Date of De			3. Time of Death
	Physici /Medi		THOMAS CHRIST	IAN, JR				APRIL	Day 2	2005	1837 N
	Examir		4a. Facility Name (If not institution,				Location of Death		4c. Cour	nty of Death	
			SAINT AGNES				IMORE If Under 24 Hrs.	10.00		NA	
	Funeral Director		5. Social Security Number 219 · 22 · 0157 Usual Residence of Decedent	7. Age (1 1 M M 2 □ F	In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da 07. DQ.	1928	9. Birth	place (State or Foreig ntry) NY
	hours after death with the Maryland turel', or Items 23e or 28e-f show all Examitter, ust be multiled at		10a. State 10b. County	_	0c. City, Town or Lo					1	10d. Inside City Limits
	Ba-fs	cto	MD BALTIN	ORE (CATONSVIL	TF					1 ☐ Yes 2 🗷 No
	with the	Dire	10e. Street and Number	CANIC		10f. Zip Code	12		10g. Citizen o		ntry?
	eath y	Funeral Director	1022 HANDY AV	ENUE 12. Was Decedent Eve	arin IIS 13			ecify Vos or No		JSA ace - Americ	can Indian
က	after d or Item	Fun	1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ No		Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	i	lack, White,	etc.
21215-0036	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2版 No	Specify:		Spec	Cify: BLA	ICK
5-0	72 h "natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation Chief	ring	16b. Kind of	Business/In	dustry
121	within 72 ene. than "nai	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 2 YKS	FNG!	NEER	Engine		WATE	R F	PONT
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. item 27 is marked other than "naturel", or Items 23e or 28e-f show other treumatic event, the Mcdfell Ex., either, usite notified at	Be Co	17. Father's Name (First, Middle, La		2,000	10021	18. Mother's Nam		Maiden Sum	ame)	20101
Maryland	Vid be Vental rrked tic ev	S S	THOMAS CHRISTI	W			GENEVA	WILLIA	MS		
lary	2 should and Men Is marke eumatic	ľ	19a. Informant's Name/Relationship	/ - \	110	ng Address (Street a	_			m, State, Zip	Code)
	1 and Health em 27 ther tr		LILLIAN CHRISTIA			HANDY A				~	
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	nemovarirom State	20b. Place of Dispo cemetery, crer			Date	20c. Location	•	
ΕĒ	permit. Pag Department Importent: I eny injury o		4 □ Donation 5 □ Other (Spe21. Signation of Fune a Service Lice		GARRISON			_			LS, MD
Ba	permit. Departi		Vanox_		VA	Name and Address UGHN C. GI 51 BALTO: 1	REENE FU	NERAL :	SERVIC	E 21279	
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or construction of the disease, or construction of the disease or condition resulting in death) Sequentially list conditions,	a. A WTE Due to (or as a company)	MYOC	ARDIAL					Approximate Interval Between Onset and Death I Hour,
	be executed ician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. END Due to (or as a c	STAGE	RENA	L DIS	EASE			3 months 5 YEARS
68760,				d. TYPER	. ,	N				1	54EARS
P.O. Box	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
	iires that signed b d be deta	y Pl	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to th	ne cause of death?
ord	w require been sig should b							1 🗆 Y	es 2X No	3 Frob	ably 4 Unknown
ecc	ie lawre has be ge 2 shi	Completed		=				24a. Was autop		. Were auto	psy findings available mpletion of cause of
<u> </u>	. The cate h	Соп						perfor	rmed?	death?	
Vital Records,	Physicien: The linis certificate harral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death				
ō	Phys r this ral dii	. To	1 Yes 2 No 27. Manner of Death	Inpatient	2 ER/Outpatien		4 Nursing Ho	me 5 Resid			y)
on	nding F tth. : After e funera	ation	1√Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Y	ear) Injury	Work	? ′es 2 □ No	200. 2000			
Division	el or Attendi s after death. el Director: A ed in by the fu	Certification;	3 🗆 Suicide 6 🗆 Could not 4 🗆 Homicide determine	be d 28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow		nber or Rura	tl Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier Check only one) Certifying 2 Medical Ex	Physician: To the best of raminer: On the basis of ex and manner stated	amination and/or inv	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the c red at the time, o	cause(s) and r date and place	manner as st	tated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	lash		29c. License			29d. Date sign		Day, Year)
6	<		- Marion	V			608		APRIL	- 12	2005 -
10			30. Name and address of person who TAULSON, GO	and the second second	h (Item 23a) (Type, AUENUE		IMORE	MT	217	20	,
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's		2 10111	1110100	2 111-	12	- 2	
	Registr			4 - 000	Z 4.	Angele .)				

ORIGINAL

		1	- For Amend Item	2 State of	dvr G84	nd / Depa 2 4-16- Cei	irtme 05 t tifica	nt of H as <i>te of l</i>	ealth and I Death	Mental Hy	ygiene Reg. No	20	05	1295
01			1. Decedent's Name (First, Middle, Las	t)						2. Date of D Month		2005 Yes	ar	3. Time of Death
	sicia ledic		Jewell		(Campbel				April		2005 Yes		12:05 AM
Exa	amine	er	4a. Facility Name (If not institution, give		umber)		_		Location of Deatl	h		County of D		• • • • • • • • • • • • • • • • • • • •
			Manorcare Potoma 5. Social Security Number 6. S		7 Age (In vrs	. last birthday)		otoma er 1 Year	If Under 24 Hrs.	8. Date of B	irth			ace (State or Foreign ry)
Fune Direc		İ		M 20 <u>X</u> F		90 Yrs.	Months	Days	Hours Min.	Sept.	lay, Year)	1914	Count Mi:	y) ssouri
			Usual Residence of Decedent											
urylan Bhow	4	_	10a. State 10b. County		10c. C	City, Town or Lo	cation						10	ld. Inside City Limits 1 ☐ Yes 2 ☑ No
Ba-f	9	Director	MD Montgom	ery	Po	tomac	1404 7	ip Code			10- 0	izen of What	Count	
with ti	9		10e. Street and Number 10714 Potomac Ten	nie Ia	TI P		101. 2	20854	'			SA	Courn	191
death with the Maryland ms 23a or 28a-f show	S C	Funerai	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Dec	edent of H	ispanic Origin? (S	pecify Yes or N		14. Race - A		
or iten	alue.		1 ☐ Never Married 2 ☐ Married	Armed I	Forces? 2 D No Give X			•	n, Mexican, Puerl	to Rican, etc.)		Black, W	√hite, e	itc.
hours after turaf, or its	TX T	1 by	3 ₩idowed 4 □ Divorced	Year or	Dates:		1 1 105	2 No	Specify:			Specify:	Wh	ite
thin 72 hours affer an "natural", or	dica	Completed	15. Decedent's Ed (Specify only highest gra	lucation de <i>completed</i>	d)	16a. Dece	kind of v	ual Occupa rork done d use retired	during most of wo	rking	16b. K	ind of Busine	ss/Ind	ustry
within then	9 N	dmo	Elementary/Secondary (0-12)	College	(1-4or 5+)		emak		7		Own	Home		
IIIQ X IX I 3-0000 be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "naturel", or Itams 23s or 28s-f show	DI,	CC	17. Father's Name (First, Middle, Last)			1101			18. Mother's Nar	me (First, Midd	4			
d 2 should be file th and Mental Hy 7 is marked oth) o	To Be	Lannis Lewis						Iva Ma	ae Garre	en			
2 should and Men is marke	e Lu		19a. Informant's Name/Relationship (Гурө, Print)		19b. Maili	ng Addre	ss (Street	and Number or Ru	ural Route Num	ber, City o	or Town, Stat	e, Zip	Code)
N	er tra	II.	Judy Campbell Bir	d – Da				1965	ım Lane (
Dallinore, Sermit. Pages 1 ar Deportment of Hea	or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from	m State	Place of Dispo cemetery, crea	matory of	other plac	1	Date		ocation - City		
t. Partmen	lury		*4 □Donation 5 □Other (Specif		J		-		etery 4- ss of Facility	14-05	St	ella,	Mis	ssouri
permit. Pages 1 Department of H Important: If its	SUC		21. Signature of Funeral Service Licen	Asselv.	1001		lark	Fune	eral Home		5.5		.05/)
			23a. Part1. Enter the disease, or com	plications that	t caused the de				od St. Ne g, such as cardia			uri 64	1831	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause or	each line.		2 2	7	000	a to	76			Interval Between Onset and Death
Pnysic /Medi	_		disease or condition resulting in death)	a. Due t	o (or as a conse	equence of):	1	,	Je Ma	100			+	410
Exami	ner		Sequentially list conditions	b	HYPE	erte.	M	COM						YRS
D	t S	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury	Due t	o (or as A onse	equence of)		-	101					,
xecute	l-tran	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a conse	equence of):		20	unn	0			-	WO,
I RECORDS, P.O. BOX 68/6U, 7X. The law requires that the death certificate be executed at the has been signed by the attending physician and	buria				1001	ed	0 N	10	-					YRS
ob/ ificate	as the	edicai		d	1									11
BOX OR leath certific attending p	esn.	ian/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of preg	nancy	Tectonic	pregnancy	,			23d. Date of		•
deat death	ed for	sicie	in the past 12 months? 1 ☐ Yes 2 Ø No		gnant at time of		Other					Month		Day Year
rat the de	etach	by Physici	9 ☐ Unknown Part II. Dther significant conditions			neulting in the u	ndarhin	CALLED CIV	on in Part I	23e Dir	1 tobacco	use contribut	te to th	e cause of death?
COLOS, P w requires that been signed b	Ded		Fall II. Dition significant conditions	orthodolog to	Geath Dat not re	saming at the t	ili Goriya iç	Cause giv	orrarr area.		Yes 2] Prob	
HECOTOS, he law requires the base been signed	shous	Completed		-						24a. Wt	as an	24b. Were	e autor	osy findings available
He lav	CI	ошо								aut	opsy formed?	prior	to cor	npletion of cause of 2 No
	director, page	Be Co	25. Was case referred to medical						26. Place of De	1 ☐ Yes ath (Check only			105	2 110
ysici	direct	0	examiner? 1 ☐ Yes 2X No	Hospital: 1 [Inpatient 2	☐ ER/Outpatie	nt 3 🗆	OOA Oth		Home 5□Re		6 Other (S	Specify)
on of ding Ph h. After th	funeral	T:UC	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Dai	te of Injury onth, Day Year)	28b. Time o	f	28c. Injur Wor	y at k?	28d. Describ	e how inju	ry occurred		
JIVISION OT I or Attending Phy after death. Director: Atter this	by the fu	Certification:	2 Accident investigatio				М		Yes 2□No	201 1	(0)	- 1 61 6	- 0	/ Davida Alicenter
or At or At or At	in by	artifi	4 Homicide determined	289. Fla	ice of Injury - At ilding, etc. (Spe		reet, fact	ory, office			own, State		r Hura	l Route Number,
spitel ours a	pellil	CC	29a. Certifier 1 ☑ Certifying PI	vsician: To t	the best of my k	nowledge, deal	h occurr	ed at the tir	ne, date and place	e, and due to th	e cause(s) and manne	r as st	ated.
UNISION OF VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific	completely filled in	edical	(Check only 2 Medical Example)	niner: On the										
To the To th	СОЩ	Me	29b. Signature and title of certifie	2			1	9c. Licens	e number		29d. Da	te signed (M	fonth,	Day, Year)
	/)		1	Kaw	Cu			D35	792		HR.	KIL,	+1	12007
,	り		30. Name and address of person who	COmpleted ca	ause of death (It	em 23a) (Type,	Print)	STO	NDR,	Roc	kv	111	E	an,
	Sta		31. Date filed (Month, Day, Year)	005 32	egistrar's Sig		ast.	,						

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month DOAM Mocil /Medical 30 CS 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth
Min. Month, Day, Bal Johns Hopkins Hospital 5. Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) place (State or Foreign 1 □ M 2 1 F 77.98.4728 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ahow City Limits other traumatic event, the Medical Examinating the notified at Director 1 Yes 2 No ACTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 0.5. by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 2 No permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", any hijury or othar traumatic event, Ita-Medical Exagnes. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) ASHIE er's Name (First, Middle, Maiden Sumame) Be 19a.,Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Namber, **DAUGHTER** 20a. Method of Disposition
1

Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Obturator Physician month /Medical Due to (or as a consequence of): **Examiner** neumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To tha Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Immunodeficiency Syndrome 3 that initiated events resulting in death) Last P.O. Box 68760 Physician/Medical esu. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy for Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Onknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Medical Certification; To Be Completed by 3 Probably 4 Whiknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one, Hospital: Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours after death.

To tha Funaral Diractor: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Could not be 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cortifio 29c. License number 29d. Date signed (Month, Day, Year) uno Medical Doc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Damian Chaupin M. Wolfe BAHIMONES NITHIANG 31. Date filed (Month, Day, Year) 32. Recetrar's Signature APR 1 5 2005 Registrar

			State of Maryland / De	partment of Health and Mertificate of Death	-	ne O O O O
	Physici /Medic		Decedent's Name (First, Middle, Last) ALBERT RAYMOND CHRISTOPH	IER JR	April 12,	2005 Year 3. Time of Death 10:00 PM
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number) Genesis Cromwell 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	Months Days Hours Min	8. Date of Birth (Month, Day, Yea	4c. County of Death Baltimore 9. Birthplace (State or Foreign Country)
	Director works	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	December 9,	1926 Mary Land 10d. Inside City Limits XX□ Yes 2□No
	th with the M 23a or 28a-f 181 be notifie	by Funeral Director	Maryland N/A Balti 10e. Street and Number 303 Rossiter Avenue	101. Zip Code 21212	10g. (Citizen of What Country?
036	urs after dea al', or Items	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2XXNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9500-91212	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or tems 23a or 28a-f show event, the Medical Examinar must be notified at	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of worki b. DO NOT use retired)	ng 16b.	Kind of Business/Industry HODDY
Maryland	ould be Mental Markad c	To Be C	17. Father's Name (First, Middle, Last) Albert Raymond Christopher Sr	18. Mother's Name	(First, Middle, Maidle	en Sumame) ery
	an eal m 2		Dorothy Martin Christopher Wife 303	Rossiter Avenue Ba	altimore,	
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ott		21 Injunature of Funeral Service Licensee AMA AMA AMA AMA AMA AMA AMA	ount Crematory 4/15/ 22. Name and Address of Facility Mit 6500 York	chell-Wiedet	ltimore, Maryland feld Funeral Home Inc more, Maryland 21212
	Prrysician /Medical					Approximate Interval Between Onset and Death
3/60,	Examiner	ical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
O. BOX 687	death certificate e attending phy, d for use as the	Physician/Medic		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ords, P	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the Dementia	e underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
al Record	The law ate has b page 2 s	e Completed	Urinary Track Infect. 25. Was case referred to medical	von	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
ion of Vital	ng Phye fter this ineral di	To B	27. Manner of Death Natural 5 Pending 2 Accident	of 28c. Injury at		6 ☐Other (Specify) jury occurred
DIVISION	i Dift o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, Sta	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	investigation, in my opinion, death occurre	ed at the time, date a	and place, and due to the cause(s)
	-3+8		30 Name and address of person who completed cause of death (Item 23a) (Type	DE059855	Ap	vil 12, 2005 nore MD 21239
) Sta Registr		April 5 2005 31. Date-Hed (Month, Day, Year) APR 1 5 2005	h Raven Blod	, Baltin	nore MD 21239

			1 - For State Registrar	State of Marylar		artment of F		l Mental Hy	giene Reg. No	DOC	12958
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of De	aath Day	y Year	3. Time of Death
1	/Medic	al	Charles Aust		c.	45 O'5 T-		April	12	2005	
	Examin	er	4a. Fecility Name (If not institution, give	1+h of Bel	A.	4b. City, Town, o	Location of De	atn		County of Deat	
	Funeral	-	Mariner Hea 5. Social Security Number 6. So	7. Age (In yrs.		If Under 1 Year	If Under 24 H		th		hplace (State or Foreign untry)
L	Director		579-26-0531	M 2□F 81	Yrs.	Months Days	Hours Mi			24 Wash	ington, DC
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary F-f she	tor	Maryland Harford		Bel A	ir					1 ☐ Yes 2 🙀 No
	th the or 28s	Director	10e. Street and Number		DCI A	10f. Zip Code			10g. Cit	izen of What Co	untry?
	ath wi	ral	312 E. Belcrest			210	14			USA	
	items iner	Funeral	11. Marital Status 1☆ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D-	14. Race - Ame Black, White	
036	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2☑ No If Yes, Give Year or Dates:	1	I□Yes 2√√2No	Specify:			Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. of other then "naturel", or items 23a or 28a-f show event, I's Medical Evarings must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	lent's Usual Occup	ation	vorkina	16b. K	ind of Business/	
121	within ne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	Rura	10 NOI use retired 1 Electr	fication	on			
9	filed v Hygie other t		17. Father's Name (First, Middle, Last)	1		Administ		ame (First, Middle			Agriculture
an	ild be lental ked c	To Be	Charles Austin	Covert, Sr.			Annabe			Ouinn	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, If a Medical Evarinar must be notified at once.		19a. Informant's Name/Relationship (7	** : *				Rural Route Numb			
	and and malth m 27		Cathy R. Price / S		_		est Road	d, Bel Ai			
Baltimore,	iges 1 if ite or ot		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	cemetery, cren	sition (Name of natory or other place		Date	20c. Lo	ocation - City or	Town, State
三	rtmer rtant rtant njury		 4 □ Donation 5 □ Other (Specify 21. Signature/of Funeral Service Licen 	110	Lan.	on Nation Name and Addre		15-05	Was	hington	, DC
Ba	Dep Impo any i		Atoch (1/1	Vicale	l M	icComas Fi	uneral 1	Home, P.A	4.	Mararlaw	J 21014
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea	th. Do not ente	er the mode of dyin	g, such as card	E., Bel A iac or respiratory a	rrest,	Maryran	Approximate Interval Between
	Physician	87 H	Immediate Cause (Final disease or condition	Right &	lower	lobe	bree	emones	_	9	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	41.	1				7-7
		-	Sequentially list conditions,	b. Sue to (or as a consec	quence of):	TANU	-				2 months
>	uted d ansit	Examiner	Sequentially list conditions, if any, learning to minimoral cause. Enter Underlying Cause (Disease or injury that initiated events	_	,						
ر و	an an	Exa	resulting in death) Last	Due to (or as a consec	quence of):						· · · · · · · · · · · · · · · · · · ·
8760,	cate be executed obysician and the burial-transit	dical		d							
9	eath certific attending p for use as	/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancv					Ord Date of deli	
Вох	death	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3	Ectopic pregnancy Other (specify)				23d. Date of deli Month	Day Year
P. O.	that the de ed by the detached	hys	9 □ Unknown	9□ Unknown					İ		
	es pe pe	by	Part II. Other significant conditions co	intributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.			7	the cause of death?
orc	w requir	eted						1 🗆 '			obably 4 Unknown
Records,	The faw ate has I page 2 s	Completed						24a. Was autoj		24b. Were au prior to death?	topsy findings available completion of cause of
Vital		0	25. Was case referred to medical		-		26 Place of D	1 ☐ Yes eath (Check only o	2 No	1 🗆 Yes	2 No
<u> </u>	ysicien: is certific director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth		Home 5 Resi		6 □Other (Spec	sify)
0 0	ng Phys fter this ineral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	/ at	28d. Describe			
Division of	ttending Phy death. ctor: After thi y the funeral o	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No	006 Learning 6	04	14/	
<u>></u>	or Attendated after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	eet, ractory, onice		City or To			ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy	ysician: To the best of my kno	owledge, death	occurred at the tin	ne, date and pla	ce, and due to the	cause(s)	and manner as	stated.
	the Hone Hone 24 the Fu	Medical	one)	iner: On the basis of examina and manner stated.	ation and/or inv			curred at the time,			
	To To	2	29b. Signature and title of certifier	Mo		29c. License	number	7	Ann	e signed (Month	Day, Year)
A	0.		30. Name and address of person who o	completed cause of death (lies	m 23a\ /Tuna	Print)			ripri	413	2005
	10		JOSEPH ANGI		S. /	47WOOD	Rd, #	1205 /	3E2	ASR	2.005 MD 21014
П	Sta Registr		31. Date filed (Month, Pay, Year) APR 1 5 2005	32. Registrar's Signa							

Charles . Covert

1 - For State Ragistrar

Physician

Examiner

/Medical

1. Decedent's Name (First, Middle, Last)

Mary

4a. Facility Name (If not institution, give street and number)

Cunzeman

Theresa

	Exami		SINAI HOSPIT	el of hAlt	IMORE	BA/	6 more	1			
	Funeral			Sex 7. Age	(In yrs. last birthda 61 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent		QT 112"			June 15	5, 1943 M	laryland	
	yland how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	ath with the Marylan s 23a or 28a-f show net be notitied at	ctor	Maryland Harford	Ē	Bel Ai	r				1 ☐ Yes ¾ ☐ No	
	or 26	Director	10e. Street and Number	_		10f. Zip Code		1	0g. Citizen of Wha	t Country?	
	s 23a		1305 St. Francis			2101				ISA	
	itams	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔀 No		B. Was Decedent of F If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	acify Yes or No- Rican, etc.)		American Indian, Vhite, etc.	
Maryland 21215-0036	72 hours after death with the Maryland natural", or Itams 23a or 28a-f show Itc.J. Exist. A. S. Prinst be rollfact at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White	
5-0	72 hours "natural"	eted	15. Decedent's E (Specify only highest gr		16a. Dec	edent's Usual Occup	pation	na	16b. Kind of Busin	ess/Industry	
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		during most of worki	9	Harford	_	
2	Hyg the int,		17. Father's Name (First, Middle, Las.	12	Plan	ning Assi	.Stant 18. Mother's Name	/First Middle A	Governm	ent	
an	Q 22 D 2	To Be	William Matthe								
ary	s 1 and 2 should be f Health and Mental itam 27 is marked other traumatic av	-	19a. Informant's Name/Relationship		19b. Ma	iling Address (Street	Mary Re		stracci , City or Town, Sta	te, Zip Code)	
	1 and 2 Health a lam 27 is		Kenneth Cunzem	an, Sr./Hush	oand 1305	St. Fran	cis Road,	Bel Air	, MD 210	14	
ore	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 [Removal from State	20b. Place of Disp cemetery, cr	position (Name of rematory or other plan	ce) [ate	20c. Location - City	or Town, State	
Ë	Pag Iment tant: jury c		`4 □Donation/ 5 🖸 Other (Speci	wEntombment	Highvie	w Memoria	1 Grdns.	4-14-05	Fallsto	n, Maryland	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatury of Fune & Service Lice	n e e		22. Name and Addre	ss of Facility uneral Hor	me, P.A.			
			23a. Part . Enter the disease, or con	unlications that caused to		50 W. Bro	adway Str	eet, Bel	Air, MD		
	Discontinuo		shock, or heart failure. List only Immediate Cause (Final	one cause on each line		0		i respiratory arre	35 1,	Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	Cancer	l			5 months	
ш	Examiner		Conventially list one distance	h	3,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1						
	D #	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	consequence of):						
B	be executed ician and burial-transif	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
60,	cate be ex physician the burial	alE		Due to (or as a	consequence or):						
68760,	ficate g phys	Physician/Medical		d							
Box	eath certific attending pl for use as t	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		□Estania programa			23d. Date of	delivery	
	D 0 D	sicie	in the past 12 months?	4☐ Pregnant at ti		☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year	
P.0	ac ac		9 ☐ Unknown ` Part II. Other significant conditions		not requising in the	dashiina aassa		One Didash			
ds,	res sign be	d by	BILLARY DI	2StRuch	ON	underlying cause giv	en in rait i.	239. Did (00	A	e to the cause of death? Probably 4 Unknown	
cor	w requir	lete	Abdami	I CARCI	1/0 MA + D	CiC		24a. Was ar	`		
Re	The law requi	Completed	- A C O DIXI NA	1 CAICCI!	VOIVIACU)13		autopsy	y prior ned? deat	autopsy findings available to completion of cause of 1?	
tal	(0 14	0	25. Was case referred to medical				26. Place of Death		No 10	res 24 No	
Į V	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth			nce 6 Other (5	Specify)	
0	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	of 28c. Injur			w injury occurred		
Sio	for Attandi after death Diractor: A lin by the fo	cat	2 Accident investigatio				Yes 2 □No				
Division of Vital Record	or A after Dirac	ertif	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory, office	2	City or Town,		Rural Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Certification:	29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, dea	ith occurred at the tin	ne, date and place, a	ind due to the ca	use(s) and manne	r as stated.	
(in 24 in 24 iha Fu	edic	(Check only 2 Medical Example)	ninar: On the basis of e and manner state	ixamination and/or i	nvestigation, in my o	pinion, death occurre	ed at the time, da	te and place, and	due to the cause(s)	
1	To T To I	Σ	29b. Signature and title of certifier	GIA		29c. Licens	e number	29	d. Date signed (M	onth, Day, Year)	
,	4		1 mys 4	·wey	M.D.	00	105491		04-11	- x 005	
	10		30. Mame and address of derson who	completed cause of dea	ath (Item 23a) (Type	Print) A	VEDERE	- AVE	BALLMON	E MT 21218	
	Sta	e	31. Date filed (Month, Da), Year)	32. Registrar	's Signature	I vo. De	IVE TETA	7.4.6.	17/41 Hirtory	e rivaian	
	Registr	_	или го Z005	Miller 1	& Span	40					
DH	MH 17 Rev 1/20	01									
					ORIGIN	AL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City Town, of Location of Death

2. Date of Death

4c. County of Death

			For State Registrar	State of	Maryland / [rtment of H		and Mental H	lygien Reg. No	2001	i 12950
	Discosioni		1. Decedent's Name (First, Midd	dle, Last)					2. Date of Month	Death Da	y Year	3. Time of Death
	Physici /Medic		Donold	Richard	Currens	2			April		2005	11:09 P M
	Examin		4a. Facility Name (If not institution		ber)		4b. City, Town, or	r Location of	of Death	40	. County of Dea	
			412 High Earl				Westm				Carro	
	Funeral Director		5. Social Security Number 220-34-7338	6. Sex 7	. Age (In yrs. last bir 67	Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (Month,	Birth Day, Year	9. Bi	nthplace (State or Foreign ountry)
			Usual Residence of Decedent		07				March	2, 1	938	Maryland
	yland		10a. State 10b. Count	y	10c. City, Tow	vn or Loc	ation	-				10d. Inside City Limits
	Mar.	ţo	Maryland Cari	roll	We:	stmi	nster					1X Yes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code	-		10g. C	tizen of What C	ountry?
	23a c	al	412 High Ear	ls Road			2115	8		ı	U.S.A	
	r dea	ner	11. Marital Status	12. Was Deced	lent Ever in U.S. es?	13. W	as Decedent of Hi	ispanic Ori	gin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - Am Black, Wh	
36	s afte , or li	by Funeral	1 Never Married 2 Ma		2 □ X No		□Yes 212No	Specify:	, ,		Specify:	18, 010.
21215-0036	n 72 hours after death with the Maryland "netural", or Itams 23a or 28a-f ahow edical Examan Loutelified at	d b	3 Widowed 4 Divorce			1		-41 - 1		100		Vhite
रं	C 3	Completed	(Specify only high	nt's Education est grade completed)		(Give k	ent's Usual Occupa ind of work done o O NOT use retired	durina mos	t of working	16b. F	Gind of Business	s/Industry
72	filed within Hygiene. other than "gant, the Med	шо	Elementary/Secondary (0-12)		₄or 5+) ⊿ Cer			•	countant	A	ccountir	na
D	ified Hygid other ant,	BeC	17. Father's Name (First, Middle						er's Name (First, Midd			ig
a	ould be Mental sarked o	To B	Paxton E	Emory Cu	rrens			F.	velyn Z	inkha	n	
Maryland	2 should land Meni is marker sumatic		19a. Informant's Name/Relation			o. Mailing	Address (Street a		er or Rural Route Nun			Zip Code)
	5 분 1		Barbara Curr	rens Wi	fe 41	12 H	igh Earls	s Roas	d Westmi	nster	. Marvl	and 21158
altimore,			20a. Method of Disposition 1 Description 2 XCremation	3 Demoval from S		of Disposi ery, crema	ition (Name of atory or other place	e)	Date	20c. L	Maryl ocation - City o	Town, State
Ë			4 Donation 5 Other (Specify)	Hillto	op Se	ervice Co	orp.	4-18-2005	To	wson	Maryland
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service	e Licensee			Name and Addres		y Ruck Tow			Home, Inc. 21204
_	70 5 9 9		Tank 10/4	hear		_	1050 York				yland	21204
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or contiplications that can st only one cause on ea	used the death. Do r ch line.	not enter	r the mode of dying	g, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Chron	ie Obstr	ruel	ive Pul.	MONA	ry Diseas	9		10 45
	/Medical Examiner		is a sum of the sum of	Due to (o	r as a consequence	of):		_				3
		La	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	r as a consequence	of):						
	uted d ansit	Examlne	Cause (Disease or injury	<		,						
Z	exectin and ial-tra	Еха	that initiated events resulting in death) Last	C. Due to (o	r as a consequence	of):						
8760	death certificate be executed e attending physician and d for use as the buriat-transit	cal		d								
9	ntifica ng ph as th	Med	IF FEMALE:	1						_		
Вох	death certifica attending ph d for use as th	an/h	23b. Was decedent pregnant		ome of pregnancy	3 □E	Ectopic pregnancy				23d. Date of de	•
O.E	e dea the at ned fo	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of death		Other (specify)			-	Month	Day Year
P.O.	that the de ned by the a detached f	Phy	Part II. Other significant condit	ione contribution to don	th hut not requiting in	in Alan	factoria a sanca a successiva	a la Danil	an Di	4400000		the server of decide
ds,	signed be det	i by	Malnutit		an bat not resulting ii	in the uno	ieriying cause give	en in Part I.		ar .		o the cause of death?
Ö	law requires as been sign 2 should be	etec	, , , , , , , , ,							`		
Vital Records,	9 2 9	Completed							24a. Wt	ODSV	prior to	utopsy findings available completion of cause of
al			05.146								1 ☐ Yes	220 No
	Physician: this certificatal director,	o Be	25. Was case referred to medica examiner? 1 Yes 22 No	Hospital:	patient 2 ☐ ER/Ou		3C DOA Othe) F	of Death (Check only		• 500 10	
o	Phys er this eral dir	-	27. Manner of Death	28a. Date of (Month)		Time of	3 DOA 28c. Injury	4 LINU	rsing Home 5 Re			icity)
ion	Attanding I ir death. ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	ing (Month, tigation	Day Year)	Injury		Yes 2 □ I	No			
Division of	er deg er deg recto by th	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 288. Place o	f Injury - At home, fa	arm, stree	at, factory, office		28f. Location	(Street ar	nd Number or R	ural Route Number,
ā	ital or rs aft rs aft rs Dii	Certification:		Danding	, ata. (opaany)				Only Gr	Own, Clare	•/	
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifyi	ing Physician: To the b I Examiner: On the bas and manne	is of examination and	e, death ond/or inve	occurred at the time estigation, in my op	ne, date and pinion, deat	d place, and due to the the control of the control of the time.	e cause(s e, date and) and manner as d place, and due	s stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certific				29c. License	number		29d. Da	te signed (Mont	h, Day, Year)
)			Dalah 2	mars	20		H53	3930	Ì	41	13/200	05
	\D		30. Name and address of person Babak Iman	0e1,00 4	12 Malcola	~ D	r. ; Suit	e 300	t; westmi.	nster	, 40	21157
	Sta Registr		31. Date filed (Month Pay, Year	5 2005	gistrar's Signature	ho	de la					

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 54 P.M JAMES DIXON nn 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 X M 2 □ F Yrs. Director 705-09-7166 87 12-20-1917 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Show 10d. Inside City Limits r than "natural", or itams 23a or 28a-f shov the Medical Examiner must be notified at MD N/A BALTIMORE 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 N. WOODINGTON ROAD 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∑Yes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>م</u> Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 6 TRUCK DRIVER BOSC LINCO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be 1 Mental I Jim Sallie Clowney ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 700 N. WOODINGTON RD., BALTO., MD 21229 AUDREY A. DIXON /WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 15☐8urial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 4/19/05 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arterioscleratio Corongry /Medical Due to (or as a consequence of) Examiner erosion -x sanguingtion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: Box esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9□ Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? pertension page 2 certificate 20 No 2 No 1 Yes 1 🖂 Yes Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 Yes 2 No this of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral I Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ayeun 00055849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 Agner /7.
32. Egistrar's Signature Gergeon Hospital 900 Caton CU 31. Date filed (Month, Day, Year) State 2005 Registrar

		1 State Registrar 1. Decedent's Name (First, Middle, L	ast)	Certif	icate of D	eath	Reg	. No. 200	5 29
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Important: If any injury or once.		21. Signature of Funeral Service Lice		ooklawn				rtland, M	Maine
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(C) 75		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?		ne 5 Residence		cify)
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#410553

DODGE, MAXINE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Docalu 11:09 AM Lawrence 2005 April 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hispital Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 30, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign **₩** 2□F Mary Land 84 Yrs. Director 216-12-7467 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show rel', or items 23a or 28a-f show Yes 2 □ No Completed by Funeral Director n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 USA 622 regatta Ave. 12. Was Decedent Ever in U.S. Armed Forces? NIXYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 white white 1 ☐ Yes 2 ☐ No Specify 3€ Widowed 4 □ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Car Sales and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Burns Lawrence J. Doody Sr. 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Larry Doody-son 6717 Foxcatcher Crt. Elkridge, Maryland 21075 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 5 Balantinore Crematory Contactory Loudon Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If eny injury or once. April 15, 05 baltimore city * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral home 21. Signature of Funeral Service Licensee 3620 wilkens Ave, baltimore, MAryland X, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocardial infarction disease or condition resulting in death) days /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit P.O. Box 68760. Due to (or as a consequence of): physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ renal uilure 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed' 1 ☐ Yes 2 ☑ No 1 Yes 20 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) RESCUL an Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21225 Monica Gicanti Harbor Hespital 3001 S. Hanover Street Baltimore, MD 32. Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year EVERETT 4:451 ERYING 2005 APRIL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA BON SECOURS BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1**Ø**M 2□F 216.30-2304 85 Yrs NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 AYes 2 No NIA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? W. ST. 21216 MOSHER USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1

Yes 2 □ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 1 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PIPE FHIER BETHLEHEM STEEL NA 8 1H GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK. JOHN EVERET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2912 W. MOSHER DEANNA C. EVERETT (WIFE) BALTO. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Surial 2 □ Cremation 3 □ Removal from State MD. NATIONAL 04.16.05 * 4 □ Donation 5 □ Other (Specify) LAUREL, MD 21. Signal re of Full tral Service License 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RICHT LUNGT PNUEMONIA DAYS Due to (or as a consequence of): LNENOWN AMTERIOSCLEROTIC HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

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MD

Funeral

Director

od other than "natural", or iteme 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other treumatic event, Ite Madic one.

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner physician and the burial-transit Physician/Medicai ass use ö þ Completed Be ၉ After the Certification: after death.

Director; Aft d in by the fur

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after To the Funerel Dire completely filled in b

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3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined			factory, o	office		28f. Location (City or To		Number or Rural Route Number,	
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PATEL 2002 W SUDKIR D 31. Date filed (Month, Day, Year) 32. Regist s's Signature 1 5 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle, Last) Day Month Vear **Physician** Kaymono 10:28 P 2005 APRII /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAL CENTER 7. Age (In yrs. last birthday) TOWSON

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. BALTIMORE GREATER BALTIMORE MEDICAL
5. Social Security Number 6. Sex 7. Age 8. Date of Birth (Month, Day, Year) 4-22-5 Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Months 497-56-8978 Director Usual Residence of Decedent 10c. City, Town or Location 10b. Count 10d. Inside City Limite 10a State show r 28a-f show 1 ☐ Yes 2 No evern Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 2 7808 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 2 No 1 Never Married Married 6 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working __tite. DO NOT use retired) The Medical 16b. Kind of Business/Industry College (1-4or 5) other then 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last, aryland Be Pages 1 and 2 should be Mental rancer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Importent; If Item 27 le eny injury or other tra once. 7808 (hevaluer Health Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Kansas Citu Forest `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility augus CGreen Funeral Services Kood Kardallotown, MD 21133 23a. Part1. Enter the desease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastanc **Physician** Nasopharyngea disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed by the should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Fuiler 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed Failur 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy has e 2 Respiratory certificate 2 No Yes To the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending To the Funeral Director: Aft

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4/13/05 00051347 Smand W untua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sociano 6701 N. Charles St. Bultimore Cynthia MD 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylan	•	artment of H		Mental Hyg	giene Reg. No.2 ()	-	12000
			Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath		3. Time of Death
1	Physici /Medic		Frances Mary Fos	ter					April	13 2	Year	02.00 AM
)	Examin		4a. Facility Name (If not institution, given Upper Chesapeake			r	4b. City, Town, or Bel Air		ath	4c. County o	of Death ford	
	Funeral Director			Sex 1□M 2√F	7. Age (In yrs. 70	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		1934	9. Birthplac Country Mary	ce (State or Foreign Land
	p .		Usual Residence of Decedent 10a, State 10b, County		10c Cit	ty, Town or Lo	cation				100	I. Inside City Limits
	shov	'n	Md. Harfor	a	100.01	-					100	1 Yes 2 No
	the N	ect	10e. Street and Number	u		рет	Air			10g. Citizen of W	hat Country	
	with Sa or	ā	200-C Timber Tra	il				2101		U.S.A.	,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exam as must be notified at ance.	y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decer Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 □ No • X		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 2 No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)		- American c, White, etc Whit	3 .
Maryland 21215-0036	2 hour	Completed by	15. Decedent's E	ducation		16a. Dece	ient's Usual Occupa	ation	entkina.	16b. Kind of Bus	siness/Indu	stry
215	thin 7. le. len "n	npie	(Specify only highest grant (0-12)	College (1-	4or 5+)	life.	DO NOT use retired		rorking	1 1		
7	ygien ygien yar th	Col	12 years			cash	ier	40. 14-15-1-1	ame (First, Middle,	books		
and	i be fil ntal H ed otl	Be	17. Fathér's Name (First, Middle, Last 01af Stromb1ad)					e Ryniewi		7	
<u> </u>	should nd Me mark mark	2	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ig Address (Street a		Rural Route Numbe		State, Zip C	ode)
Σ	alth ar 27 is r trau		Mary Foster/daug	hter		2363	Spring V	allev R	oad, Lanc	aster.	PA 176	601
re,	s 1 av		20a. Method of Disposition		1 0	Place of Dispo	sition (Name of natory or other plac		Date	20c. Location - 0		
Ē	Page nent c ant: If ary or		1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Speci				em. Gdns.		8/2005	Bel A	ir, Mo	1.
Baltimore,	permit. Departn Imports any injt		21. Signature of Funeral Service Lice		Home of Bel Air, Inc. ad, Bel Air, Md. 21014 respiratory arrest, Approximate							
			23a Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the deat	th. Do not ent	er the mode of dying	g, such as cardi	ac or respiratory ar	rest,	l Ir	pproximate iterval Between
	Physician		Immediate Cause (Final disease or condition	High	Gra	de L	umuho	ma w	ilk Me	tas Jesu	j j1	nset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a conseq	quence of):	J. J.		,,,,			
	LAdinnei	<u>_</u>	Sequentially list conditions,	b	or as a conseq	mence of/:						
e	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (0	7 23 2 001130 4	(de1100 01).						
Ć,	cate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (d	or as a conseq	juence of):						
8760,	ysicia ysicia	dicai	(d						 		
9		Medi	IF FEMALE:									
P.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		rth 2 ☐ Feta ant at time of d	al death 3□	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Da	ay Year
<u>.</u> ت	res that igned by be deta	by Pr	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	oute to the	cause of death?
rds	w require: been sig should b								1 U Y	es 2 No	3 Probab	ly 4 □Unknown
Vital Records,	aw re	Completed							24a. Was autop	an 24b. W	ere autops	y findings available letion of cause of
m m	The tav	mo:							perfor	med? de	path?	No
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				101		eath (Check only o	пе)		
2	hysio this c	2	1 ☐ Yes 2 No			ER/Outpatier		4 Nursing	Home 5 Resid	ence 6 Othe		
nc On C	ling F	ion:	27. Manner of Death 1		n, Day Year)	28b. Time of Injury	28c. Injury Work	rat {? Yes 2 □ No	200. Describe II	ow injury occurre	u	
Division of	Attsnc death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 280 Place	of Injury - At h	ome, farm, str	eet, factory, office			treet and Numbe	r or Rural F	Route Number,
Ö	al or /	erti	4 Homicide	buildin	g, etc. (Specil	(y)			City or Tow	n, State)		
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certifications in the funeral director, completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the la miner: On the ba and mann	sis of examina	owledge, death ation and/or in	occurred at the time vestigation, in my op	e, date and pla pinion, death oc	ce, and due to the c curred at the time, c	ause(s) and mar date and place, a	ner as state	ed. ne cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	2//			29c. License			29d. Date signed		-
)	7			- n	10		200	5660	7 1	April 13	3/4 3	2005
	10		30. Name and address of person who Joseph Am	completed cause	of death (Item	m 23a) (Type,	Print) ATWOO	D Rd	, #205	BELF	1_K ,	MD 21014
	Sta Registr		31. Date filed (Month, Day, Year)	R 1 5 200	gistrar's Sana	ature	1. Spark	e e				

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			State of Maryland / Department State of Maryland / Department State Stat	artment of Health and I tificate of Death		giene200	5 12968	
	Physicia /Medic Examin		Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death	
			Theodore H. Franklin		April 1	1. 2005 Ye	3:00 A.M	
			4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	h	4c. County of E		
			Lawrel Regional Hospital 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday)	Lawrel If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince		
	ineral ector		5. Social Security Number 5. Social Security Number 6. Sex 1 △ M 2 □ F 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.		1926 U	Birthplace (State or Foreign Country) USh. D.C.	
	color		Usual Residence of Decedent		Juec. 7,	1720 W		
arylan	Show	_	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
he M	items 23e or 28e-f show rec'must be notified at	Director	RI. Newport Newport	10f. Zip Code	1.	l 0g. Citizen of Wha		
with		Di	109 Chaplain Place North	02840		United St		
death		Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - A	American Indian,	
after	or ite	Fur	1 X Never Married 2 ☐ Married 1 X Yes 2 ☐ No	f Yes, specify Cuban, Mexican, Puèrt I □ Yes 2[X No <i>Specify:</i>	o Hican, etc.)	Cif	Vhite, etc.	
lours	tal Hygiene. id other than "neturel", event, the Medicul Exe	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				White	
n 72		Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of woi DO NOT use retired)	rking	16b. Kind of Busine	ess/Industry	
4 with jiene.		mo	Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Arts	ist		Federal	Gout.	
a filec	othe vent,	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle,			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	Health em 27 ther t	Tol	Richard B. Franklin		ee Sulli			
12 sh h and			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Byron E. Franklin - Brother 109 Chaplain Place North, Newport, RI. 02840					
1 and Health				sition (Name of natory or other place)		20c. Location - City		
Pages nent of	nt: Ki		1 Burial 2 **Cremation 3 Removal from State ** 4 Donation 5 Other (Specify) **Salto./Wax	04/40/	05	Laurel, N	(D.	
permit. F Departm	mporter any injur 2008.		21. Signature of Funeral Service Licensee 22	. Name and Address of Facility	leck Fun	eral Home	e, Inc.	
- 40		M00869 7601 Sandy Spring Road, Lawrel, MD. 20707 Ta. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Appropriately.					Approximate	
Dhu	ysician						Interval Between Onset and Death	
	edical		Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery 1 Due to (or as a consequence of):	rseuse			Many Years	
Examiner	miner		Sequentially list conditions b.					
pe	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
xecute	physician and the burial-transit	хап	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):					
9,00	sician s buria	dical E						
tilicate	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledic						
th ce		Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of Month	23d. Date of delivery Month Day Year	
9 dea		sici	in the past 12 months? 1 Yes 2 No 9 Unknown	Other (specify)		Worth	Day 16a	
that th			Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribut	te to the cause of death?	
uires .		d by	Hypertension		1 🗆 Y	es 2. No 3 □	Probably 4 Unknown	
5 e		olete			24a. Was a	ın 24b. Wer	autopsy findings available	
The la		Completed			autops perform 1 Yes	med? prior deat 2 X No 1 =		
<u> </u>		Be C	25. Was case referred to medical examiner?					
hysic		٦ ک	1 ☐ Yes 2 🕱 No Hospital: 1 🛣 Inpatient 2 ☐ ER/Outpatien			ence 6 Other (Specify)	
ding F		Certification:	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe no	ow injury occurred		
Attend		fical	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str.				r Rural Route Number,	
el or l		Serti	4 Homicide building, etc. (Specify) City or Town, State)					
Hospit 24 hours		Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
ro the	omple	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (M	Ionth, Day, Year)	
F 5	- 0		1 Goorapm	D23181	,	April 11.	2005	
10+			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.G. Bhojraj, M.D. 704 Gorman Ave., T-1. Lawrel, MD. 20707					
;·	Sta Registr		31. Date filed (Month, Day, Year) APR 1 5 2005 APR 1 5 2005					
c *	registi	ļαI	LINT O COOL WELLING IN					

DHMH 17 Rev 1/2001

			tate of Maryland / D			ntal Hygie	ene	10000
		1 - State Registrar		Certificate of L		Reg Date of Death	. No.4 UUD	12969
Physici	an	1. Decedent's Name (First, Middle, Last)		Fleto	ih=a A	Month	Day Year	3. Time of Death
/Media		4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town, or	Location of Death	(4 h l l v l	L LOOS 4c. County of Death	11.511
Examir	iei	The Johns Hopk	ins Hospito	4 Baltit	HORE Cit	9		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bird	Months Davs		Date of Birth (Month, Day, Y	(ear) 9. Birthp	lace (State or Foreign
Director		Usual Residence of Decedent	5/	Yrs.	19	AY 15, 19		GINIA
yland yland		10a. State 10b. County	10c. City, Town	n or Location			1	0d. Inside City Limits
a-f st	ctor	PENHSYLVANIA YORK	STÉ	WARTS TOWN				1 Yes 2 No
or 28	Director	10e. Street and Number	154 1.10	10f. Zip Code	2/3	100	g. Citizen of What Cour	itry?
s 23a	eral		MILL ROAD Was Decedent Ever in U.S.		363	Ves or No-	14. Race - Americ	an Indian
Defitition (e) Interpretation 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Medical Evant arrival terricillist at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origini (Specify n, Mexican, Puerto Ric	an, etc.)	Black, White,	etc.
72 ho	eted	15. Decedent's Educat (Specify only highest grade of	on 16a.	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of working	16	b. Kind of Business/In-	dustry
vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	2222 77	_	MEDICAL	
idilia 2 12 ld be filed with ental Hygiene ked other tha ic event, the	e Co	17. Father's Name (First, Middle, Last)		ARKETING KEP	18. Mother's Name (F	irst, Middle, Ma		
should be nd Mental marked o	To Be	EDWARD E	ANDREW		LUTIE S	TRONG	ì	
2 shou and M and M is mar is mar aumat	-	19a. Informant's Name/Relationship (Type,	Print) 19b.	. Mailing Address (Street a			City or Town, State, Zip	Code)
E, M 1 and 2 Health (Health	MRS. ANN M. BYRD	SISTER 8	806 CARDINAL		REL, M	ARYLAND 2	0723	
Pages 1 nent of He int: If Iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem	comotos	Disposition (Name of ry, crematory or other place	e) Date	1 - 1	oc. Location - City or To	
partition permit. Pages Department of Important: If I any injury or once.		'4 □Donation 5 □ Other (Specify)		W CREMATORY	ss of Facility MAR	05 01	ACTIMORE MA	RLAHD
Deart permit. Deport Import any inj once		21. Signature of Funeral Service Licensee	call-	6009 HARK			/	TO VOICE
		23a. Part1. Enter the disease, or complication	ons that caused the death. Do r					Approximate Interval Between
Physician		shock, or heart failure. List only one of Immediate Cause (Final disease or condition	PULLION (AY	ry embo	liem		6	Onset and Death
/Medical		resulting in death)	Due to (or as a consequence	of):				23141114162
Examiner	L	Sequentially list conditions, b if any, leading to immediate	occult ve		nrombo	515		WEEK
/ pe ist	nlner	cause. Enter Underlying	Due to (or as a consequence		EBRAL	I NI = U	กบรม	and are
sxecui n and al-trai	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence		reorm	NIVER	113371	CJANS
cate be executed physician and the burial-transit	dical	d						
	1 03	IF FEMALE:						
death certif	ian/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death				23d. Date of delive Month	ery Day Year
the de	Physician/M	1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)				
ecords, P.O. BOX of law requires that the death certific as been signed by the attending of should be detached for use as	by Ph	Part II. Other significant conditions contri	outing to death but not resulting in	n the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
w requires been sign						1 🗌 Yes	2 No 3 Prot	ably 4 Dunknown
Heco le law re has bee	plet					24a. Was an autopsy	prior to co	psy findings available impletion of cause of
The The ate h	Completed					performe		2 No
OI VIKAI F Physician: Th rhis certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital:	strations 25 DOA Othe	26. Place of Death (C			
ding Phys	- To	1 N Yes 2 No	28a. Date of injury 28b. 1	Itipatient 3 DOA Time of 28c. Injury Work	4 Nuising Home		ce 6 Other (Specifinjury occurred	y)
oding th. : Afte	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		k? Yes 2 ∐No			
DIVISION I or Attending after death. I Director: After d in by the fune	Certification:	a Could not be	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factory, office	281	Location (Stre City or Town,	et and Number or Rura State)	il Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C		an: To the best of my knowledge : On the basis of examination an and manner stated.					
To the within To the Comp	ž	29b. Signature and title of certifier		29c. License			I. Date signed (Month,	
		1 /Len	en & M.D.	KES	>-000	A	PRIL 14	2005
(1)		30. Name and address of person who comp	leted cause of death (Item 23a)	(Type, Print) NOVY WOL	16 chair	Ralt	- 110 - 10	1 21187
U	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	J NOVITY WOL	ire street,	DUITIMO	x muziur	W 0/207
्र Regist		FPR 1 5 2005	Blow &	beach "				
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ORIGINAL

		1	For State Registrar	State of M	arylan				lealth a		lental Hy	/gien	£ U U U	1000	2970
	٠		Decedent's Name (First, Middle, Las	t)							2. Date of D			3. Tir	ne of Death
Phys			Phyllis Elizabeth	Funkhous	a r						April		ау ^{Үөөг} 2005		3:37A M
/Me Exai	edica		4a. Facility Name (If not institution, give				4b. City	, Town, or	r Location o	of Death			c. County of De		3.07.11
LAGI	1111110	7.	Casey House Hospie	re			Roc	kvil	le			M	ontgome	rv	
Fune	ral		5. Social Security Number 6. Se	7. Ag	je (In yrs.	last birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B				ate or Foreign
Direct	_		160-16-5258	□M 2[X]F	85	Yrs.	IVIOITIN	Days	110013	IVIAI.	Oct.	21,	1919 Pe	nnsy1	vania
p ,		-	Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	antine.							10d Insi	de City Limits
aryla		_			100. 01	y, rown or Lo	Cation								Yes 2 ∑No
Na M 8a-f		۔ ا	Maryland Prince G	eorge's_	Laur	el	101 7	. 0. 1.				10- 0	itizen of What (71.
with t		<u> </u>	10e. Street and Number				107. 2	ip Code	_						
sath s 23		Funeral Director	12236 Apache Tear	S Circle 12. Was Decedent	Ever in 11	S 13	Was Dec	20708		igin? (Sne	offy Vas or N		ted Sta		nn
tar da itam		ů,	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	>	.3.	If Yes, sp	ecity Cuba	an, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)		Black, Wh		
Us af ui', or		by	3 ★ Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 X No	Specify:	:			Specify: W	hite	
I Z I 3-UU30 within 72 hours after death with the Maryland ane. sne. then "natural", or items 23e or 28e-f show then "natural" and wides Examiner and the political and the solution of the so			15. Decedent's Ed	ucation		16a. Dece	dent's Us	ual Occup	ation			16b.	Kind of Busines		
7 Find 7 Find 7		pie	(Specify only highest grades) Elementary/Secondary (0-12)	College (1-4or	5+\	life.	DO NOT	use retired	during mos d)	st of worki	ng				
a gian		Completed	12			Admir	nistr	ativ	e Ass	ista	nt	Pe	ople's	Drug S	Store
be fila hist Hy od othe		Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	e, Maide	n Sumame)		
aryiand should be fill nd Mantat Hy marked oth		2	Austin Levi Roth						Eva	Ruth	Kunk1	3			
IVE, IMARYIANG ZIZIS-UUSO Is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mariat Hygiene. Item 22 is marked other than "natural", or items 23s or 28s-1 show other traumatic event. It is Mucal Examinating to 20ling a			19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Addre	ss (Street	and Numbe	er or Rura	al Route Numi	ber, City	or Town, State	, Zip Code)	
e, IVI			Deborah Funkhouse	r/Daughte									MD 207		
Saltimore, barmit. Pages 1 av Dapartmant of Hea mportant: if item			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. F	Place of Disposementery, cre	osition (Name of the control of the	ame of other plac	ce)		Date	20c. l	Location - City of	or Town, Sta	te
baltimory parmit. Pages Dapartmant of H important: if its			' 4 □Donation 5 □ Other (Specify		Koa	ias Cen	leter	у	A				Jackso	n, VA	
mrmit.	ouce.		21. Signature of Funeral Service Licen	seen	CCC	0321 2	2. Name a	and Addre	ss of Facili	al Ho	ome, In	nc.			
n 80 5 5	ä		Mancyet.	Dessel	le	/ P.	O. B	ox 6.	3, Mt	. Ja	ckson,	VA	22842	Approx	
Physicia /Medic Examin	er	Examiner	23a. Part1. Enter the disease or composition, or hear failure. List only of the composition of the compositi	a. End Sta Due to (or as	age I	ementi									il Between and Death
ata be axacutad atsubaracutad bysician and the burial-transit			resulting in death) Last	Due to (or as	a conseq	uence of):									
Ita ba ax ysician		cal	(d											
tificating phy as this		Med	IF FEMALE:									T		1	
COTGS, P.O. BOX 68/ wrequires that the death certificate bean signed by the attending phys should be detached for use as the		Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	I death 3	⊒Ectopic ⊒ Other (pregnancy specify)	/				23d. Date of d Month	elivery Day	Year
ecords, P.O. law raquiras that the as baan signed by th		by Pr	Part II. Dther significant conditions of	ontributing to death t	out not res	ulting in the u	ınderlying	cause giv	en in Part I	1.	23e. Did	tobacco	use contribute	to the cause	e of death?
rds quiras n sign											1 🗆	Yes :	2 X No 3 □ 1	Probably	4 □Unknown
ecord taw raquir as baan s		Completed									24a. Wa		24b. Were	autopsy find	ings available
Y 00 - C 00		E C										opsy formed? 2X N	death		of cause of
VITAL P sician: Th certificata		Ö	25. Was case referred to medical						26. Place	e of Death	n (Check only		10 10 10	33 2 2 1 1 1 0	
90		0 8	examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatie	nt 3 🗆 [Oth					6 NOther (Sp	ecity) Hos	spice
		ä	27. Manner of Death	28a. Date of Inju	ury Voarl	28b. Time o	of	28c. Injur Wor			28d. Describe				JP ICC
nding i		atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ay roar,	Injury	М		Yes 2	No					
DIVISION To the Hospital or Attending within 24 hours after death. To the Funaral Director: After		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At h tc. <i>(Speci</i> l	ome, farm, st	reet, facto	ory, office			28f. Location City or To		and Number or i	Rural Route	Number,
ne Hoapi n 24 hour ne Funar		Medical		ysician: To the best niner: On the basis of and manner si	of examina										use(s)
To the	3	Σ	29b. Signature and title of certifier	1			2	9c. Licens	e number	. ,	2	29d. D	ate signed (Mo.	nth, Day, Ye	ear)
6			(SHOW)	M				DI	112	120		t	1/7/	05	
,	7		30. Name and address of person who						•				-1 -1		
	~		Charles M. Harris				astei	Mil.	1 Roa	d, Re	ockvil.	le,	MD		
Rec	Stat	1.0	31. Date filed (Month, Day, Year)	2005 32. Projist	rar's Sign	ature	bare	0							

		State of Maryland / Department of State of State		ental Hygier	2005 1007.
Physic		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)	20,09	2. Date of Death	Day Year /2:10 PM
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Prince Georges
Funera Director	_	5. Social Security Number e. Sex 7. Age (In yrs. last birthday) 218-08-9053 1 M 2 F 33 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) 971 Maryland
D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
e Man Ja-fsh	ctor	MD Prince George Laurel			1 ☐ Yes 2 No
with th	Funeral Director	10e. Street and Number	10f. Zip Code 20707		Citizen of What Country?
leath ms 23	eral	#2 Dell Place 11. Marital Status 12. Was Decedent Ever in U.S. 13. y	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		USA 14. Race - American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Noulcal Exprises minister indifficult	þ	1 Never Married 2 Married 1 ☐ Yes 2 No	If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 🎇 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
In 72 ho	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	16b.	. Kind of Business/Industry
filed withle Hygiene. Sther than ent, the M	lmo Jul	Elementary/Secondary (0-12) College (1-4or 5+) 11 Sr. Ac	dministrative Assi		Neighbor Care
be file	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	,
allyland	은	William N. Hauger 19a MTCHATAMe/Relationship (Type, Print) 19b. Mailin	DONNA MA	rie Kalbo Route Number, Cit	
E, Ma 1 and 2 s Health ar em 27 ls other trau		William Fox - Husband #2 De.	ll Place, Laurel,		
Pages 1 and of Hermint: If item	1	1 Burial 2 A Cremation 3 Hemoval from State 1	natory or other place)		Location - City or Town, State
permit. Pag Department Important: I any injury o		' 4 □Donation 5 □Other (Specify) Chesapeak 21. Signature of Funeral Service Licensee 22	ke Crem., Ind. 4/14,	/2005 Be	eltsville, MD
permit. Depart Import any inj		Tauma 172	250 Washington Blv	i., Elkric	
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	1 11		Approximate Interval Between Onset and Death J.Z. h.c.s
/Medical Examine		resulting in death) Due to (or as a consequence of):		0	
	Je L	Sequentially list conditions, if any, leading to immediate cause. Enter U. Jerrying Cause (Disease or injury)			
and I-transi	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
ate be executed only sician and the burial-transit	cal E	d			
A OO entitica ding ph		IF FEMALE: 23c. If yes, outcome of pregnancy			004 Day 44 K
he death of the attent	Physician/Med	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
wrequires that the death certitics been signed by the attending phe should be detached for use as it	by	Part II. Other significant conditions contributing to death but not resulting in the un Night Coy Dec Venes Two-50515	nderlying cause given in Part I.		ouse contribute to the cause of death? 2 🔄 No 3 🗀 Probably 4 🗀 Unknown
ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the buriat-transit	Completed	Intracerebal Aneurysm, Right He	miparesis.	24a. Was an autopsy performed	
VICAL Ician: 1 Sertitical ector, p	Be C	25. Was case referred to medical examiner?	26. Place of Death		10 163 22.10
Physic This ce	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien			6 ☐Other (Specify)
ding Fig.	tlon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
or Attending after death. Director: Attelin by the tune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structured building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death check only one) 1 Medical Examiner: On the basis of examination and/or invand manner stated.			
To the within To the compl	₩e	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
/		30. Name and address of person who completed cause of death (Item 23a) (Type,	D46120	19/	Dril 12, 2005
り		+ Decem 10724 Cittle	Rotuxent	PkJg (Julia 170 21044
. Regis	tate strar	APR 1 5 2005 APR 1 5 2005	We '		

2005

ROBERT GINN

			1 _ Stata	State	of Marylan		irtment <i>tificate</i>			Mental Hy	_	office of		
			Registrar 1. Decedent's Name (First, Middle,	Lacti			incate	01 L	Journ	2. Date of De	Reg. No.	200	J 3	Time of Death
	hysici	an	MARJORIS		Gree	abor	0			Month _	Day		r	1728 M
	/Medic	al					\circ		Leasting of Door		10		02	1120
	Examin	er	4a. Facility Name (If not institution,	~					Location of Deal	ın	46.	County of De	ain	
			University 2		YLAND	In at histhele	If Under 1		MOVE If Under 24 Hrs	8. Date of Bi	rth.		lintrala	(Ctata or Foreign
	uneral		5. Social Security Number	6. Sex 1 □ M 2754 F	7. Age (In yrs.			Days	Hours Min.	. (Month, D	ay, Year)	/ I	Country). (awai	(State or Foreign
וט	rector		Usual Residence of Decedent			3				5-1	2-19	36		
and	M +4		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. l	nside City Limits
Aary	e pe	0	Maryland Prince	Georges	Gr	eenbel	t							I □Yes 2 XNo
the	288-	Director	10e. Street and Number	OCOLGED	01	CCIIDOL	10f. Zip C	Code			10a. Citi	zen of What	Country?	
¥.	"natural", or items 23a or 28a-f ehow valcal Exsoluer must be notified at		6980 Hanover P	arkwav #	201			2077	70			USA	,	
eath	18 23	Funeral			cedent Ever in U.	S 13 V				Specify Yes or N	0-	14. Race - Ai	nericen la	ndian.
ier d	Tien .	Ľ,	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed F	orces?	10.1	Yes, specif	fy Cuba	n, Mexican, Puer	to Rican, etc.)		Black, W	hite, etc.	
S af	, or	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or	ive	1	I□Yes 2	No No	Specify:			Specify:	AS	ian
P Po	tura H		15. Decedent			16a. Deced	lent's Usual	Occupa	ation		16b. Ki	nd of Busine	ss/Industr	у
27 0	an and	Completed	(Specify only highes			(Give life. L	kind of work DO NOT use	done d retired	furing most of wo	orking				•
with ene.	the	E C	Elementary/Secondary (0-12)	5 College	(1-4or 5+)	Home	maker				,	Own Ho	ome	
filed	ant, I		17. Father's Name (First, Middle, I	.ast)		1			18. Mother's Na	me (First, Middle	, Maiden	Sumame)		
d be	o per	o Be	Kame Miyasato						Kana N	akasone				
ally failed 4.1.4.1.5.0000 should be filed within 72 hours after death with the Maryland of Mental Hydiene.	is marked other then aumatic event, the Me	2	19a. Informant's Name/Relationsh	in (Type, Print)		19b. Mailin	a Address ((Street a	and Number or R	ural Route Numb	er, City o	r Town, State	, Zip Cod	fe)
d 2 s	7 is trau		Wayne K. Green		m)					airfax,			•	1
1 and Health	thar		20a. Method of Disposition	Derg (50	20b. P	lace of Dispo	sition (Name	e of	100	Date		cation - City	or Town,	State
Pages 1	- H 15		1 ☐ Burial 2X Cremation			emetery, cren erly Fu				/05		fax, \		
r. Pa	tant		'4 □Donation 5 □ Other (Sp											
permit. Pag Department	important: If item 27 is marked other then "naturany injury or other treumstic event, the Medical once."	1	21. Signature of Funeral Service I	licensee	Market Street or a second	22				verly Fu				
- 40	= a a								-	Fairfax		. 2203		
			23a. Part1. Energy le disease, or since l'interes l'inte	complications that only one cause on	each line.	h. Do not ent	er the mode	of dying	g, such as cardia	ic or respiratory a	arrest,		Inte	oroximate erval Between set and Death
Phy	sician		Immediate Cause (Final disease or condition		12	tuuk	C	nes	st tro	auma			011	ter CC .
	edical		resulting in death)	Due to	o (or as a conseq	uence of):	,		1 0	suma			1	
Exa	miner		Cognectially list conditions	b	\sim	1040,	- Ve	hic	lecro	SN.	Ai	d.m	W/C	EUS.
/ 7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conseq	uence of):				. 1	16	0		(
cute	ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с						M		MINER		
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cate be executed	physician and the burial-transit	dical		d					1 pu	du Mon APPROVED BY				
I i i	as th			T					CENTRICATI	01.	- 1			
5 8	nse	Z	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Feta		Ectopic pre	ionancy				23d. Date of o	,	
deat	d for	lc la	in the past 12 months?	4□Preg	gnant at time of d		Other (spe					Month	Day	Year
, å	ache	Physician/Me	9 □ Unknown	9 Unk	nown									
s tha	signed by the attending p d be detached for use as	by P	Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	nderlying car	use give	en in Part I.	23e. Did	tobacco u	se contribute	to the ca	use of death?
in e	n sig d blu									1 🗆	Yes 2	□No 3□	Probably	4 Unknown
) ĕ	should should	lete								24a. Was		24b. Were	autopsy t	findings available
D e e	cate has t	ompleted									ormed?	death	?	tion of cause of
<u> </u>	ficate or, pa	e C	25. Was case referred to medical						OR Plans of Do	1 ☐ Yes	2 LNo	1 U Y	es 21Z	440
Sicia Sicia	is certific director,	o Be	examiner?	Hospital:	Ileasticat O	ED/Outration	4 2C DO4	Othe	or			COther (C	nanifu)	
5 £	ral di	H	17 Yes 2 No 27. Manner of Death		Inpatient 2 e of Injury	ER/Outpatien 28b. Time of				Home 5 Res 28d. Describe			оесну)	
g ig	After	lo l	1 Natural 5 Pending) (Mo	nth, Day Year)	1400	M	Bc. Injury Work	Yes 2121No	mata.	- 10	hicle	((sch.
ttan	actor: After th by the funeral	Ca	3 Suicide 6 Could r	ot bo	e of Injury - At he		eet factory			28f. Location				. 4
or A	Dira in by	Certification:	4 Homicide determ	ned buil	ce of Injury - At he ding, etc. (Specif	y)	coi, idoloiy,	011100		City or To	wn, State	1	24	Ú.
pital	erai ed		On Cartifar 1 Cartifyin			udodes desti	a conversed o	e the sim	an data and plac		000		ac clated	
To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.	To the Funeral I	edical		g Physician: To the Examiner: On the										
the Shin 2	mple	Med	29b. Signature and title of certifier	ano ma	and stated		290	License	e number		29d. Dat	e signed (Mo	nth, Dav.	Year)
J.	F S		Last of the control o	1 () mx	7 0				171	572				~
	5		1 Morry	D'IL		MSICIA			ι (14		-1-	10.	-01
6	7		30. Name and address of person		1 1		Print)		110 1	eene St	7	11	11/1	MD 51501
	V		University		civy and		40 >	70n	111 01	exite 31	()	24 1711	VIOIC	6101
	Sta Registr		31. Date filed (Month, Pay Year)	5 2005	gistrar's Signa	Le L	- 00							
	Registı	al		-505	RAWLE .	D 1	Belle 1							

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237	í						ont of Hoalth and				egible.	
			1- State Unpend Item Registrar	23a&27 per	me G844	ertifica	ate of Death	ı ivie	niai myg	eg. No.	005	12974
	Physici	212	1. Decedent's Name (First, Middle, L	ast)				2	Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Greg Stephen Go						April_	4, 20	005	10:52 P ^M
1	Examin	er	4a. Facility Name (If not institution, gi		. 1		ty, Town, or Location of De	eath			ounty of Death	
			Howard County Ger 5. Social Security Number 6.		tal e (In yrs. last birtho		olumbia der 1 Year If Under 24 F	irs o	Data of Birth		vard Co	
	Funeral Director		218-82-9748 Usual Residence of Decedent	150M 2□F 43		Month			Date of Birth (Month, Day)7-11-	1 961	Nor	place (State or Foreign intry) th Dakota
'	/land		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
	Man,	ţċ	Md Howard		Columbi	a						1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f.	Zip Code		1	0g. Citize	n of What Cou	intry?
	23a	ai	9242 Hobnail Cour	rt			21045			U.S	. А .	
	tems tems	nue	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was De If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specification (Speci	y Yes or No- can, etc.)		Race - Amer Black, White	
36	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Madical Exatinat must be notified at QRCs.	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ∰ Divorced	1 ☐ Yes 280 N If Yes, Give/ Year or Dates:	lo	1 🗆 Yes	200 Specify:			S	рөсіfy:Whit	e
ဗို	2 hou	ted	15. Decedent's 8	ducation	16a. D	ecedent's U	sual Occupation			16b. Kind	of Business/Ir	ndustry
Maryland 21215-0036	hin 7.	Completed	(Specify only highest g	rade completed) College (1-4or 5	- li	ive kind of fe. DO NO	work done during most of v Tuse retired)	working				
7	od wit gjene er th	Con	12		<u>'</u>	Self 1	Employed			Cons	tructio	n
ם	tal Hy d oth	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's N	Name (F	First, Middle,	Maiden Su	ımame)	
<u> </u>	Men	T _o	Roger Charles Go				Donna					
a Na	hand 7 is n traun		19a. Informant's Name/Relationship	(Type, Print)			ess (Street and Number or			-		
رة آ	1 end Heelt em 2 ther		Donna Goupil 20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Place of D		onail Court	Co1			yland 2 tion - City or T	
nor	ages int of t: if it y or o		1 Burial 2 Cremation 3		cemetery,	crematory of	crotherplace) Crematory 04-					Maryland
Baltimore,	nit. Partme ortan Injur.		21. Signature of Funeral Service Lice				and Address of Facility				_	-
ä	ped language of the control of the c		10/12/13/11/2	0		700 S.	Beechfield	Lse	runera Ralt	imor	rvices Maru	P.A. dand 21220
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused	the death. Do not						e, mary	Approximate Interval Between
} 1	Physician		Immediate Cause (Final disease or condition			diova	scular diseas	se c	complic	ated	by	Onset and Death
	/Medical Examiner		resulting in death)	fátty, l	Versequence of)							
	Examiner	L	Sequentially list conditions,	b								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):							
	al-tra	xar	that initiated events resulting in death) Last	c Due to (or as	a consequence of)							
760,	ite be executed sysicien and he burial-transit	cail		d								
9	leath certificat attending phy I for use as the											
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal death	3 □Ectopio	pregnancy			230	d. Date of deliv	
0	The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Cther	(specify)				Month	Day Year
<u>Ч</u>	that the de led by the a detached f	Phy	Part II. Other significant conditions	contributing to death b	ut not resulting in th	ne underlyin	a cause given in Part I		23e Did to	hacco use	contribute to	the cause of death?
ds,	w requires that been signed be should be det	d by	•			io anaony ii	g vaavo givoiriir rairii			es 2 🗆 t		N
So	w req	Completed				-11		_	24a. Was a	n is	24h Wara aut	opsy findings available
Re	he lav e has age 2	duic						-	autops perfori	med?	prior to co death?	impletion of cause of
ta	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of D	Death ((-	2□No	1 SYes	2 No
⋛	Physici this cer al direc	To B	examiner? 1X Yes 2 □ No	Hospital: 1 Inpatie	nt 2/2 ER/Outpa	atient 3	Other				Other (Speci	fy)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	y 28b. Tim		28c. Injury at Work?		d. Describe h			
Sio	eath. or: Af	catic	2 Accident investigati	on		M	1 ☐ Yes 2 ☐ No					
Division of Vital Records,	or Attendate death Director:	Certification;	3 Suicide 6 Could not 4 Homicide determine		ury - At home, farm c. (Specify)	, street, fact	ory, office	28	. Location (Si City or Town		Number or Rur	al Route Number,
Ц	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying F	Physician: To the best	of my knowledge, d	leath occurr	ed at the time, date and pla	ace and	due to the c	auso/s) an	nd manner as	stated
	ne Hor	Medical		aminer: On the basis of and manner sta	examination and/o	r investigati	ion, in my opinion, death of	ccurred	at the time, d	ate and pl	ace, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	.)(29c. License number		2	9d. Date s	signed (Month,	Day, Year)
			Thudu	U. K.	us		OCME			Ap	cil 4,	2005
			30. Name and address of person who		eath (Item 23a) (Ty	pe, Print)	.11 Penn Stre		Ro1+4	mo 22 -	M1	and 21201
			31. Date filed (Month, Day, Year)		ar's Signature	т	.11 10111 2016	CL	Daltl	more,	raryl	and 21201
	Sta Registi		APR 1 5 200		-	met 1						

1- State Registrar AMEND ITEM #18&19a PER FH G849 rtificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Physician Lo On Henderson, Jr. 12 /Medical 4a. Facility Name (If not institution, give street and number) , 4b. City, Town, or Location of Death Examiner GlenBu Arundel nie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1∰M 2□F Hours Min. 71 183-28-6390 Yrs Director 11, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Pasadena Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 United States 344 Rambling Ridge Ct. "netural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within 72 Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, Ite Made once. Elementary/Secondary (0-12) College (1-4or 5+) Cook 6 17. Father's Name (First, Middle, Last) Be Lo On Henderson, 19a. Informant's Name/Relationship (Type, Print) Judy Henderson / Wife 20b. Place of Disposition (Name of 20a. Method of Disposition April 20, cemetery, crematory or other place) 1 Burnal 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Pk. 21. Signatur f Funeral 59 Vice Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Spiratory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑No į 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ Completed peen 24a. Was an certificate has 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Restaurant 18. Mother's Name (First, Middle, Maiden Sumame)
Julie Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAMBLING Ridge Ct., Pasadena, MD 21122 20c. Location - City or Town, State Elkridge, Maryland Name and Address of Facility
rkley-Ruddick
Crain Hwy., S.E., Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year)

Reg. No.

Year

14. Race - American Indian, Black, White, etc.

Asian

2005

4c. County of Death

Anne Ar

Specify

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Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

Pennsylvania

11:48 AM

Registrar DHMH 17 Rev 1/200 29a. Certifier

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day,

GAV 1P4

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

5 2005

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32. Regitrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item/14, per FH, G042, 4/15 (Department of Health and Mental Hygiene Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 9:328 HARTMAN APRIL 2005 /Medical give street and number, 4b. City, Town, of Location of Death 4a. Facility Name (If not institution. 4c. County of Death Examiner ALTIMORE Year If Under 24 Hrs. last birthday) 8. Date of Birth Funeral Days 1 M 2 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at Completed by Funeral Director 1 Yes 2 No MDALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. WHITE 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

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16a. Decedent's Usual Occupation

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16b. Decedent's Usual Occupa 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h item 27 20a, Method of Disposition ~ <u>=</u> Burial 2 Cremation Department of Important: If any injury or once. PARKLANUNS MEMORIAL ^¹ 4 □ Donation 5 □ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical sequence of): Due to (or as a c Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Denknown 295. Were autopsy findings available prior to completion of cause of death?

1 2 S 2 No autopsy 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes TNo 1 Inpatient Medical Certification; To 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred latural 5 Pending investigation 1 Yes 2 No Accident within 24 hours after deal To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day Month **Physician** 0925 Koland /M 03 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** OSPITAL OR NIA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 4 - 1 8 - 4) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 150 M 2□F 219-26-8728 Yrs. Director Usual Residence of Decedent death with the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limijs 28a-f show other treumatic event, the Medical Exeminer must be notified at Completed by Funeral Director Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ō or items 23a Was Decedent Ever in Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Caban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 22 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-40) 5+ if Heelth and Mental Hygiene. Elementary/Secondary (0-12) ruck Driver 10th CRADE Iransportati 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame To Be illiam Maryono 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, (State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brother) 2814 Fallsmont William tallston 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Pimportant: If its eny injury or of once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, MD -14-05 1 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C Greene Funeral Sinks berty Rd. Randallstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suit is cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** - un /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading transported cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner igned by the attending physicien and be detached for use as the burial-transit The law requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performed After this certificete 2**X**No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours elter death. To the Funerel Director: After this cartifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

Registrar

Thory wan

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

APR 1 5 2005

GERALD HOFEIL



and manner stated.

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

			1- For State of Maryland		artment of H		nd Ment	, ,	ene g. No.	.•
	Physici /Medio Examin	cal	1. Decedent's Name (First, Middle, Last) HAZY LODGE 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	E	eate of Death	The same of the sa	S 1:22 P M
	Funeral Director		Riverview Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last 213-30-4618 Usual Residence of Decedent	st birthday) Yrs.	ESSEX If Under 1 Year Months Days	If Under 2 Hours	Min. (A	ate of Birth Month, Day, Ly 22,	Year) 9.	Ore Co. Birthplace (State or Foreign Country) Pennsylvania
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. A feet the mas 23a or 28a-f show other treumatic event, it is Medical Examinational terministics.	Director	10a. State 10b. County 10c. City, Maryland Harford 10e. Street and Number 2115 Harkins Road	Town or Lo		esvill 21132		1	g. Citizen of What United S	•
	72 hours after death neturel', or Items 23 afcet Examilier i us	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origi n, Mexican, Specify:	in? (Specify \ Puerto Ricar		14. Race - A Black, W	umerican Indian, /hite, etc. White
1717	filed within 72 h Hygiene. Ither then "netu ent, Ine Medical	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years 17. Father's Name (First, Middle, Last)	(Give life. l	dent's Usual Occupa kind of work done d DO NOT use retired, LTPESS	luring most			6b. Kind of Busine Restaur	•
Marylan	and 2 should be tealth and Mental m 27 Is marked o her treumatic eve	To Be	Theodore McMaster 19a. Informant's Name/Relationship (Type, Print) Wayne L. Hoppe (Son)		ng Address (Street a	Mary and Number	y Sal	yards ute Number.	City or Town, Stat	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State	Lawn	sition (Name of natory or other place Cemetery . Name and Addres uda=Ruck	4/14	Date 4/2005			e, Maryland
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. Box 6	death certific e attending p id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 4 Pregnant at time of deal 9 Unknown	death 3	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year
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Ä	The la ate has page 2	Be Completed	Defetés Defetés 25. Was case referred to medical examiner?				_		ed? prior death	
no no	ing Phys After this uneral dii	Certification: To	1 Yes 2 Hospital: 1 Inpatient 2 El 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	P/Outpatien 28b. Time of Injury	28c. Injury Work M 1 \(\sqrt{1} \)	4 E Nuis	28d. I	Describe hov	nce 6 Other (5 w injury occurred	Specify) Rural Route Number,
5	pitel or urs afte erel Dir	edical Certif	4 Homicide determined 226. Flace of injuly - Art form 29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowl and manner stated.	ledge, death	occurred at the tim	ne, date and pinion, death	place, and d	City or Town,	State) use(s) and manner	r as stated.
	To the Hos, within 24 ho To the Func	Me	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 2	23a) (Type	29c. License				d. Date signed (M	
3	Sta Regista		Michael Schwartz, M.D. 7310 Rich 31. Date filed (Month, Day, Year) APR 15 2005	nie Hv	vy. Suite	508 G	Glen Bu	ırnie,	MD 210	51

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year April 0900 Dorothy Overmiller Harkins 10. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford If Under 1 Year | If Under 24 Hrs. al Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🔯 F 216**-**30-8503 3/10/1914 Kansas Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Harford Churchville 1 ☐ Yes 2 ZNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 Rolling Green Drive 21028 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis C. Overmiller Maude Levina Carlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Maxwell Ct., Churchville, Maryland 21028 Charlsie H Brooks - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bel Air Mem. Gardens 4/15/ 2005 Bel Air, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) premer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 🗀 🗤 0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide

Director oriant: If itam 27 is marked other than "natural", or itams 23a or 28a-f show injury or other traumatic event, the Madical Examshar must be notified at Director Completed 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked of any injury or other traumatic **Physician** /Medical **Examiner** Examiner burial-transit the attending physician Physician/Medical detached Completed certificate has After this Harkins within 24 hours after death To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 03227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) machha. 615 · 2/2 31. Date filed (Month, Day, Year) 2. Registrar's Signature APR 1 5 2005 Registrar

Dorothy

Funeral

anend item/8 perfri, \$42,4/25/00 II State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Helein B Hall MY 8:40 p 98 2665 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birthow 6, 1912 Birthplace (State or Foreign (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2 F 92 215-16-6153 2005 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "neturel", or Items 23s or 28e-f show ury or other treumatic event, the Medical Examinations at Items 25. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 ☐ Yes 2 ☐ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 Flamingo Drive 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. White Completed by 3 ☐ Widowed 4 🏲 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burton John W. Norma 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is eny injury or other tret once. 1103 Flamingo Drive., Baltimore, MD 21227 (Sister) Mary Nettleship 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 H Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4/13/05 Baltimore, Maryland A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Department Arteriosclemote Corman Unader Driese Physician 1000 disease or condition resulting in death) /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, I any, leading to in rediale cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner and I-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physiclan a use as the burial-P.O. Box 68760. Physician/Medicai IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ trikhown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteo poronis has e 2 autopsy performed: hypotegrand certificate 2□ No 1 Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No this After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funerel I
completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D19667 04-09-2005 9 uciail' around 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7310 Retelier Hypersony \$ 508 Gleu Borner, Mariand 21061 McClear Jacobian St. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar egistrar's Signature

APR 1 5 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** HINES. 14:19 PM HOWARD 12th APRIL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Levindale nursing Home **BAltimore** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 220-38-7494 Yrs. 63 24, 1941 MAry1and Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: if item 27 is marked other then "netural", or items 23e or 28e-1 show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or itams 23a or 28a-f shov 1 Yes 2 □ No Director MD **BAltimore** Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 340 Bryanstone Rd. 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1□Yes 2√No Specify: white þ Specify: white 3 ☐ Widowed 4 ☐ Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) 12 Sheet Metal Worker Northrop Grumman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Louis Hines Sr. Mary Genevieve Karner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAry Lou Hines- wife 340 Bryanstone Rd. Reisterstown, MARyland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: if its any injury or ot once. ty⊟Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Apr. 15, 2005 BAltimore City *4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, MAryland 21229 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. CORONARY ARTELY DISEASE 2 YEARS /Medical Due to (or as a consequence of): Examiner CANCER 3 45175 METASTATIC COLON Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): attending physiclan a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy performed page certificate 2 No 1 Yes 2 210 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending М 1 Yes 2 No 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours after To the Funeral Dira 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12th 2005 Donna M. Everely m.O. D054739 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Belvedere Avenue, Baltimore Maryland 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

State of Manyland / Department of Health and Mental Hydiene

1. Decedent's	Name (First, Middle,	Last)				2. Date of De		tub	3. Time of Death
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	fler de	-un	11. Marital Status 1 ☐ Never Married 2 ☐ M	Armed	ecedent Ever in U. Forces? es 2 X No	.5.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.))- 14. F	Race - Ameri Black, White,	
ဗ္ဗ	al', ol	þ	3 ☐ Widowed 4 🙇 Divorc	If Yas	Give r Dates:		1□Yes 2∰No	Specify:		Spe	cify: BLA	1CK
ည	be filed within 72 hours after death with the Maryland ntal Hygiene. od other than "natural", or Items 23a or 28a-f ehow event. The Medical Examinational by notified at	Completed		ent's Education rest grade complete	ed)	16a. Deced	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	cina .	16b. Kind of	f Business/In	ndustry
2	within nne. ihan *	mpl	Elementary/Secondary (0-12) Colleg	(1-4or 5+)			OFFICER		STATE	00	4/10
N O	filed w Hygier ther th		12 TH GRADE 17. Father's Name (First, Midd.		IA	WKKE	CHOIGHE	18. Mother's Nam	e (First, Middle	- 1		MD
Maryland 21215-0036	be d c d c d d c d	To Be	LOUIS LOWMA					VIOLETIA			,	
lary	nit. Pages 1 and 2 should artment of Health and Men ortant: If Item 27 le marke injury or other treumatic: 8.		19a. Informant's Name/Relation			4	ng Address (Street					o Code)
ຂ ໜົ	l and lealth im 27 her tr		LOUIS E. LON	IC, UAM			MONTELLO					
Baltimore,	Pages I nent of H int: If ite iry or ot		20a. Method of Disposition 1 ■ Burial 2 □ Crematio		om State	emetery, crer	sition (Name of natory or other plac	(e)	Date		on - City or To	own, State
를	permit. Pag Department Important: Ii eny injury o		'4 □Donation 5 □ Other 21. Signature of Fune all ervi	A	AKE	surus	Name and Addres	04 · I		BALTO.		
Ba	permit. Departm Importa eny inju		2) auch	CI		VĀ	Name and Addres WGHN C. G 151 BAUO.	NATI PIRA	UNERAL BAIT	SERVIC	E 21229	
			23a. Part1. Enter the disease, shock, or lear ailure. L	or complications th	at caused the deat							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	*		VTRICI	JLAR H	EMMORH	AGE .			Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a conseq	uence of):						
	Examine	-	Sequentially list conditions,		YPERTER		J ·					10 YEARS.
	nted Insit	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	₹	10 10 20 20 20 100							
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8760	ate be executed hysician and the burial-transit	dical		d								
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Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 Liv	outcome of pregna re birth 2 Feta egnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	,		1	Date of deliv Month	ery Day Year
P.O.	that the death certificed by the attending podetached for use as	Physician/Med	1 □ Yes 2∜☑No 9 □ Uпклоwп		nknown	eaui 5						
	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	by Pł	Part II. Other significant cond	itions contributing t	o death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	obacco use c	ontribute to t	the cause of death?
rd	w require been sig should b								1 🗆	Yes 2□No	3 ☐ Prol	bably 4 Unknown
Division of Vital Records,	e law requ has been je 2 shoul	Completed							24a. Was		b. Were auto	opsy findings available ompletion of cause of
<u> </u>	The sate h	Corr								rmed2- 2√2 No	death? 1 ☐ Yes	·
VIE V	ician: Sertific ector,	Be	25. Was case referred to med examiner?	Hospital:			Oth	26. Place of Dea				
o	Phys this ral dir	To:	1 Yes 2 No 27. Manner of Death	1		ER/Outpatier		er: 4 🗆 Nursing Ho	ome 5 Resi			fy)
O	Attending Physician: r death. sctor: After this certific by the funeral director,	tlon	1 ☑Natural 5 ☐ Pen	ding (A stigation	ate of Injury fonth, Day Year)	Injury	Worl	k?` Yes 2 □No	EGG. BGGGIIGG	now anjudy con	001100	
VISI	or Attending I after death. Director: After in by the funer	Certification:	3 Suicide 6 □ Cou	ld not be 28e. Pl	ace of Injury - At he ilding, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location (City or To	Street and Nu	mber or Run	al Route Number,
	tal or A	Cert	4 - Homeos		morny, etc. (Specif	,, 			City of 10	WII, State)		
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medic	ying Physician: To al Examiner: On th	 basis of examina 	wiedge, deatl ition and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the	cause(s) and date and place	manner as s	stated. to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of cert		nanner stated.		29c. License	e number		29d. Date sig	ned (Month.	Dav. Year)
1	F 3 F 8		▶ Mone?	2415h			917	608.		APPI	, 0,	2005
	1		30. Name and address of pers	on who completed o	ause of death (Iter	n 23a) (Type,	Print)	- 08		111 6	- 1	
1	U		DR MERCY &	JACKSON	J, 900 je	ATON	AVENU	E,BAL	TIMOR	SE. V	102	Day, Year) - 2005 .
	Sta		31. Date filed (Month, Day, Ye	ADD 1 5	Registrar's Sona	ature	is property					
	Registi	ar		WILL TA.	7	2/						

JOHNSON, BARBARA.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 3 501 Jahnson Verser /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, give street and number) Examiner nursing Baltimore Manor Home 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 09 04 Year) 25 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M XIXF 416-20-6301 Director Usuel Residence of Decedent 1 and 2 should be filled within 72 hours after death with the Maryland Health and Mantal Hygiana. Sen 27 is marked other than "naturel", or items 23s or 28s-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or flems 23s or 28s-f shor traumetic event, the Medical Examiner must be notified at 1⊠Yes 2□No Funeral Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 U.S.A. 2102 Chelsea Terrace 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 217 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: à 3 ₩ Widowed 4 Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Federal Government 12th grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lessie Mitchell 9 Pages 1 and 2 should Mack Scott 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code, Dorothy McKinney Everett 2121 Windsor Garden Lane, Apt 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if any injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) 4/18/05 Randallstown, Md King Memorial Park 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pert1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) seme Examiner Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of): P.O. Box 68760. by Physician/Medical Due to (or as a consequence of) Obsthin for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed Jon venue 1 ☐ Yes 2 ☐ No 1 Ves 2LINo Division of Vital after daath.

Director: After this certific
J in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred or Attanding 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atta within 24 hours after da To the Funeral Directo complataly filled in by th 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D31464 4/13/05 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) St frute 308 13 nlt. m) 21201 821 SHOAUS N. EUTAN A · HASHMI 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar Marian DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

		Please I	State of Maryland / Dep		•	•
		1 - State Registrar	· ·	ertificate of Death	, 0	g. No. 2005 1298
		Decedent's Name (First, Middle, Last)			2. Date of Deat	h 3. Time of Death
Physic /Medi		Samuel	Taylor	James	AP KI L	1 ² 2 ⁴ , 2005 5:50а м
Exami		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death)	4c. County of Death
		RICHIE HIGHWAY & AC		GLEN BURNIE		ANNE ARUNDEL
Funeral		5. Social Security Number 6. Sex	IM 2□E Van) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	
Director		214-51-8783 "Usual Residence of Decedent	33 ***s.		05 14	71 Nigeria
ryland how		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
e Ma	ctol	MD NA	Baltimo	ore		1 X Yes 2 No
ith th	Director	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Country?
be filed within 72 hours after death with the Maryland tal Hygiene. Indicate then "netural", or iteme 23a or 28a-f ehow event, I've Medical Examinar must be notified at		2 Otley Ct. Apt		21244		U.S.A.
ter de item	Funeral	11. Marital Status 1 ↑ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes of No- o Rican, etc.)	14. Race - American Indian, - Black, White, etc.
urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
2 hou	Completed	15. Decedent's Edu	cation 16a. Dec	edent's Usual Occupation	dein =	16b. Kind of Business/Industry
ad within 72 hours aff giene. er then "netural, or	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	Killy	
D 0 9	S	12th grade	3yrs Inc	dustrial Cleane		Various Offices
id 2 should be file lih and Mental Hy 27 is marked oth treumatic event	Be	17. Father's Name (First, Middle, Last)	1-		ne (First, Middle, M	
2 should be filed v n and Mental Hygie is marked other t reumatic event, III	2	Taylor James Et			olomon	City or Town, State, Zip Code) 20072
D = C =						
The Hear		I. Hope Umara-F	20b. Place of Disp	to LOCG FAIFLAX cosition (Name of ematory or other place)		Upper Marlboro, 20c. Location - City or Town, State
Sages ent of ht: If i		1X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	enioval nom State	emorial Park 4/	22/05	Randallstown, Md
permit. Pages 1 a Department of Hes importent: if item eny injury or othe		21. Signification of Funeral Service License		Aarch F/H West	22/03	Randalistown, Md
perm Depa impo eny is		Flyn 5		1300 Wabash Ave	. Balti	more, Md 21215
		23a. Parti. Enter the disease, or compli shock, or hear failure. List only or	cations that caused the death. Do not er			
Physician		Immediate Cause (Final disease or condition	Muttale Inju	~ [?] 0 ^		Onset and Death
/Medical		resulting in death)	Due to (or as a o nsequence):	103		
Examiner		Sequentially list conditions).			
od sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
and -trans	хаш	that initiated events resulting in death) Last	Due to (or as a consequence of);			
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	calE					
death certificate attending physical attending physical attending physical attentions.			1.			
eath certii attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy			23d. Date of delivery
death e atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
that the de ed by the a detached f	hys	9 🗆 Unknown	9□ Unknown			
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Physi this c	2	1X Yes 2 No 27. Manner of Death	lospital: 1 Inpatient 2 ER/Outpatie			nce Cher (Specify)
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i or Attending after death. Director: Afte	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, s	^	28f. Location St	reet and Number or Rural Route Number,
after after Dire	erti	4 Homicide	building, etc. (Specify)	,	City or Town	, State) Richie Highway an
spite nours nerei		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, dea	ath occurred at the time, date and place	, and due to the ca	ause(s) and manner as stated.
To the Hospitel or Attending Physibin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical	(Check only 2 XMedical Exami one)	ner: On the basis of examination and/or i and manner stated.	investigation, in my opinion, death occu	rred at the time, da	ate and place, and due to the cause(s)
To the within To the comp	×	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Month, Day, Year)
/		I hig his, i	n i)	OCME	l A	APRIL 12, 2005
h		30. Name and address of person who co	empleted cause of death (Item 23a) (Type			
			mid	111 Penn Stre	et Balt:	imore, Maryland 21201
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sand &		
Regist	rar	APR 152	UUJ Bleever St. A	The state of the s		

			1 - For State Registrar	State of Ma	arylan		artmen tificate			and M		giene	005	12986
	Discort.		1. Decedent's Name (First, Middle, I	.ast)	•						2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Briddie			John	son				4		2005	8:50p M
	Examin		4a. Facility Name (If not institution, g				4b. City,	_		of Death		1	unty of Deat	th
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	Funeral Director		305-16-7313	. Sex 7. Age	e (in yrs. i 84	ast birthday) Yrs.	Il Under Months	Days	Il Under Hours	Min.	8. Date of Birth (Month, Day 11-3	, Year) -20	9. Birt	chplace (State or Foreign ountry) Ga.
	MC M		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
;	Mary -1 sh	ţo	Md. NA	!		Balti	more							¥ Yes 2 □ No
,	r 28a	Funeral Director	10e. Street and Number		<u> </u>		10f. Zip	Code				10g. Citizer	of What Co	ountry?
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	deat	ner	11. Marital Status	12. Was Decedent I Armed Forces?			Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)	14.		nican Indian,
2	or th	Y.F.	1 Never Married 2 Married	1 1√2 Yes 2 □ N	No		1 ☐ Yes		Specify:	1, 1 00.10	mount, Gro.,			
Ś	ural'	d by	3 X Widowed 4 □ Divorced	Year or Dates:		10. B	feede Dece	10					· B	lack
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9	Ald be Ald be riked tice.	To B	Thomas		Joh	nson			Flo	oreno	ce		Tav	lor
<u> </u>	s 1 end 2 should be filed within 72 hours effer death with the Marylend f Health and Mental Hygiene at the "natural", or items 23a or 28a-f show flasm 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notilied at	•	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street ar			l Route Numbe	r, City or To		
	end and m 27 m 27 ner tr		Corlee Acors	Daughter					Hill		. Seve			144
ב כ	permit. Peges 1 end 2 Depertment of Health a Importent: if Itam 27 is any injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. P	lace of Dispo emetery, cren	sition (Nan natory or o	ne of ther place)	D	ate	20c. Locat	ion - City or	Town, State
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			shock, or heart failure. List or	ly one cause on each lir	ne.			_			r respiratory ar	rest,		Approximate Interval Between Onset and Death
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200	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal	death 3	Ectopic pr					23d	. Date of del Month	ivery Day Year
	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of de	eath 5∟	Other (sp	ecify)						,
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ecords,	uires sign d be	d by	Hypertension.	Renal Failu	are,	Ischem	ic H	Pe.Ct	Disea	er See	1 🗆 Y	es 2 🗆 N	lo 3□Pr	obably 4 dinknown
2	w requir been si should	lete	Diabetes M	ellitus							24a. Was	an 2	4b. Were au	itopsy findings available
ב	Physicien: The favithis certificete has al director, page 2	Completed									autop perfor	med?	prior to death?	completion of cause of
VII	en: T	O	25. Was case relerred to medical						26. Place	ol Death	1 ☐ Yes (Check only o		1 🗆 Yes	2 No
<u> </u>	ysici is cer direct	To B	examiner? 1 Yes 2 No	Hospital:	ent 2	ER/Outpatien	nt 3 DC				ne 5□Resid		other (Spe	cin Paughter's
5	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju	ry v Year)	28b. Time of	2	8c. Injury Work			28d. Describe h			Home
VISION	endir sath. or: Af he ful	atic	2 Accident investigation	tion			М		es 2 🗌	No				
Ĕ	or Att frer de lirect n by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina				eet, factory	, office		4	281. Location (S City or Tow		umber or Ru	ıral Route Number,
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	othi othi omple	Me	29b. Signature and title of certifier	and mainer ste			290	. License	number			29d. Date s	igned (Monti	h, Day, Year)
	F > F 0		Patrick	Doman	m		i	004	61889	1		April	13	2005
	140		30. Name and address of person wh	no completed cause of d	eath (Item	1 23a) (Type.	Print)							
	101		Patrick Sosnay	Johns 1	tople.	as Ito	spital	18	30 Eas	st Me	nument	Street	Bouth	more MD 21287
	Sta		31. Date liled (Month, Day, Year)	32. egistr	ar's Signa	ture	reals !							
	Registr	rar	APR 15	LUUJ BIE	2	5 14	-							

		1	For Stete Registrar	State of Maryland	d / Depa		of H	ealth a		ental Hygi	ienez	005	12987
	Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Last) Last			4b. City, 1	Town, or	Location o	. 0	2. Date of Death Month	Day 12	Year O 5 ounty of Death	3. Time of Death
Di	uneral irector		5. Social Security Number 212-22-4430 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under:	•	8. Date of Birth (Month, Day, 01-22-	Year) 1921	9. Birth Cou	place (State or Foreign ntry) MD
the Maryland	28a-f show notified at	ector	10a. State 10b. County MD N/A 10e. Street and Number	10c. City	BALT	IMORE	Code			10	og. Citízer	n of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No X
:1215-0036 within 72 hours after death with the Maryland	od other than "natural", or ltams 23a or 28a-f show evant. It's Modical Examinet must be notified at	Funeral Director	1921 W. FAYETTE S	TREET 2. Was Decedent Ever in U. Armed Forces? 1		Was Deced If Yes, spec				cify Yes or No- Rican, etc.)		USA Race - Ameri Black, White	, etc.
21215-0036 3d within 72 hours af	an "natural", o	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)	Year or Dates:	16a. Deced (Give life.	1 ☐ Yes 2 dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	luring mosi }		ng	16b. Kind	pecify: BL	
Maryland 21, id 2 should be filed will the and Mental Hydien.	marked other than	To Be Con	6 17. Father's Name (First, Middle, Last) LOUIS BENJAMIN JA	CKSON	TEXT	ILE WO	ORKE	18. Mothe		(First, Middle, A		HING	
6 - a	tam 27 Is		19a. Informant's Name/Relationship (Tyr. MYRTLE JACKSON/DA) 20a. Method of Disposition 1 Burial 2 A Cremation 3 Re-	UGHTER 20b. P	1600 lace of Dispo	O VINO	CENT ne of ther place	CT.	, BA		MD		
Baltimore,	Important: If i any injury or once.		`4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	"a, Morta	n	2. Name an	d Addres	s of Facilit	JAM 'NS S	ES A. MO	ORTON LIMOR		S F.H., INC
/M	ysician and ledical aminer transit	cal Examiner	23a. Part1. Enter the disease, or complishock, of heart failure. List only on disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence)	uence of):	er the mode	e of dying	g, such as	cardiac o	r respiratory arre	RTE	ASE ASE	Approximate Interval Between Onset and Death
Records, P.O. Box 68 The law requires that the death certifical	by the attending phy tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	death 3	□Ectopic pr □ Other <i>(sp</i>					230	d. Date of deliv	very Day Year
ords, P.	b ee n signed by should be deta	þ	Part II. Dther significant conditions con	tributing to death but not resi	ulting in the u	inderlying ca	ause give	en in Part I			oacco use		the cause of death?
	certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical				,	26. Place	e of Death	24a. Was a autops perform 1 Yes 2	ned?	24b. Were aut prior to c death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
← ≥	within 24 hours after death. To tha Funarel Diractor: After this cert completely filled in by the funeral direct	Certification; To B	examiner?	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifications)		M 2	8c. Injun Worl	er: 4 🗆 Nu	ursing Hor	ne 5 🗌 Reside 28d. Describe ho	once 6 [ow injury o	occurred	ral Route Number,
ha Hospital	in z4 nours a ha Funarel I pletely filled	edical		sicien: To the best of my kno ner: On the basis of examina and manner stated.		vestigation	, in my o	pinion, dea		ed at the time, d	ate and pl	ace, and due	to the cause(s)
Tot	- Company	N	29b. Signature and title of certifier 30. Name and address of person who see	gran	23a) (Type	7	2	o number	73	6	FFK	signed (Month	2 2005
	æ Sta		EDWARD BY 31. Date filed (Month, Day, Year)	32 Registrar's Signa	MD	ali Z	200	0 W	PA	-CTIM (RE	72	21223
	Regist	relr	APR 1 5 200	13 PHOREUSE A	17	54C							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 6.50PM **Physician** JACOUELINE JENKINS Hpri 1.3 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Health 900, Caton Ave Balting 18 If Under 1 Year If Under 24 Hrs. N/A Care, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Hours 63 NORTH CAROLINA 218-42-2523 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location or 28e-f show other treumatic event, the Medical Exeminer must be notified at 1 Yes 2 No N/A BALTIMORE MD. Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Items 23a 2839 BOOKERT DR. 21225 USA Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: BLACK Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced 'netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) -12-SOCIAL WORKER SOCIAL WORK -4-. Pages 1 and 2 should be filed w iment of Health and Mental Hygier tent: If Item 27 is marked other th jury or other treumatic event, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIE PERKINS ESTELLA MONROE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2839 BOOKERT DR. BALTIMORE, MARYLAND 21225 CLEVELAND JENKINS (HUSBAND) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Cemetery, crematory or other place)
PERKINSVILLE BAPTIST 1 ☑ Burial 2 ☐ Commation 3 ☑ Removal from State

1 ☑ Donation 5 ☐ Other (Specify) permit. Page Department of importent: If any injury of once. 4-20-2005 LELAND. NORTH CAROLINA HIGH CEMETERY Address of Facility PHILLIPS FUNERAL HOME, P.A. ral Service Licensee JONATHAN 21. Signature of 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage Kenal 10 your **Physician** /Medical Due to (or as a consequence of) **Examiner** mouth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 10 vous 11 et me ue to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ♀️ No page 1 ☐ Yes 22 No Be 25. Was case referred to medical 26. Place of Death Check onl one Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Hospitei or Attending Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) , 900, Caton Ave, Baltimore, MO, 21229 t-Agnes Health Cevre 32. Registrar' signature 31. Date filed (Month, Day, Year) 2005 Registrar

			For State Registrar	State of Maryland / Depa	artment of Health and M tificate of Death	ental Hygien	1000 12000
	Physici		1. Decedent's Name (First, Middle, Last,	JAWORSKI		2. Date of Death Month	ay Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		c. County of Death
	Funeral		5. Social Security Number 6. Se	TM 005	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	82		nov-24,10	
	Maryla a-f shov	tor	10a. State 10b. County	10c. City, Town or Lo	*		10d. Inside City Limits 1 □ Yes 2 No
	with the	Director	10e. Street and Number		10f. Zip Code 2)208	10g. C	itizen of What Country?
	er death Itams 23	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
900	72 hours after death with the Maryland natural; or itams 23e or 28e-f show oral Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Married 5 ☑ Widowed 4 ☐ Divorced	Year or Dates: W. W. II	Yes 2 No Specify:		Specify: WHITE
21215-0036	<u></u>	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+) (Give life, L	lent's Usual Occupation kind of work done during most of worki OO NOT use retired)	ng 16b. I	Kind of Business/Industry
	otha /ant,	ادها	17. Father's Name (First, Middle, Last)	1432	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(First, Middle, Maide	n Sumame)
Maryland	Men Men arka	To B	FRACK 19a. Informant's Name/Relationship (7)	AWORSKI 19b. Mailin	g Address (Street and Number or Rura	I Route Number, City	or Town, State, Zip Code) 31014
	and 2 sealth ar m 27 is		JANET LLARY	13312	BESTER SLIAN	O BULA	ir MARYLAND
Baltimore,	0 0		20a. Method of Disposition 1 Burial	Removal from State 20b. Place of Dispo	sition (Name of natory or other place)	1	Location - City or Town, State
Balti	permit, Pag Department Important: I any injury o		21. lign to of Funer (Service Licens			122 - BEL	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death. Do not entended to be cause on each line.	er the mode of dying, such as cardiac of		Approximate Interval Between Onset and Death
	Pnysician /Medical	ě y	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	e cardiom	y spath	y year
	Examiner	ē		b. Due to (or as a consequence of):			
p	te be executed ysician and e burial-transit	Examin	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
8760,	cate be e ohysician the buris	dicai E		d			
Вох 6	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		Ectopic pregnancy		23d. Date of delivery Month Day Year
P.0	res that the de igned by the a be detached		9 Unknown	9□ Unknown ntributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ords,	w requires been sign should be	ted by	Liver fail	usue, renor (fa	: Core	1 ☐ Yes 2	2 No 3 Probably 4 Unknown
Vital Records,	The law rate has be page 2 sh	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita	ician: certifica rector, I	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Othor	n (Check only one) me 5 ☐ Residence	6 X Other (Specify) / Los
	ding Phys h. After this funeral dii	tion: To	27. Manner of Death 1 Accident 2 Accident	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how inju	
Division	or Attan after deal Diractor: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or Attanding I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Medicai Ce	29a. Certifier Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my knowledge, death ner: On the basis of examination and/or invand manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause(ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the within 7 To the Comple	Med	29b. Signature and title of certifier	1 1	29c. License number	1	ate signed (Month, Day, Year)
,	XI	- 5	30. Name and address of person who c	omposed cause of de 16 litem 23a) (Type,	Print) M. Charles St.	dp	r. 10, 2005
1	\\		31. Date filed (Month, Day, Year)	CAME 6701	N. Charles St.	Bulto	md 2(20x
I	Sta Registi		ΔPR 1 5 2005	82. Registrar's Signature			

amend item#5, per Frint in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year April 5:45 a Thomas <u>Jenkins</u> 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore
If Under 1 Year | If Under 24 Hrs. 1108 W. Hamburg St. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 213-32-9167 1**⊈**M 2□F Months Days Hours Yrs. Director 4, 1936 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits in than "naturel", or Items 23a or 28a-f show the Medical Expressions that he notified at N/A Director Maryland 1. Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 W. Hamburg St. Completed by Funeral 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If itam 27 Ia marked other than "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Peacetime 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Welder of Health and Mental Hygis If itam 27 Ia marked othar or othar traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Jenkins 0 Mvrt1e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia A. Jenkins (Wife) 1108 W. Hamburg St., Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) = 5 permit. Page Department of Important: If any injury or Loudon Park Cemetery 4/16/05 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dooth Immediate Cause (Final Priysician LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Lissass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached is certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2∏ No of Vital 1 Tes 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only or Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at 28d. Jescribe how injury occurred 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? Manger of Death 28b. Time of Division 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29b. Signature and D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE BALT. MD 21229 AGNES COLE 31. Date filed (Month, Day, Year) State Registrar

	For State Registrar	State of Maryla		artment of H		F	Rag. No. 20 (05 129	9 1
Physician /Medical	1. Decedent's Name (First, Middle Steven	Ra	ıy		ham		2, 2005	3. Time of Dea 1:34a	M M
Examiner	4a. Facility Name (If not institution UNIVERSITY HOSE 5. Social Security Number	TTAL 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	ORE CI	TY Hrs. 8 Date of Birtl	4c. County of		reign
Director	218-90-2986 Usual Residence of Decedent 10a. State 10b. County	1X ² M 2 □ F 40	Yrs.	Months Days	Hours 1	Min. (Month, Da) 06 2	6 64	Birthplace (State or For Country) M D	
with the Maryla a or 28a-1 shov be notified at Director	MD N.		Baltin	nore	-		10- 0:	10d. Inside City Lin	
nrs after death value, or Items 23	10e. Street and Number 4310 Ridgewood 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Miloroced	12. Was Decedent Ever in Armed Forces?		10f. Zip Code 212 Was Decedent of Hilf Yes, specify Cuba 1 Yes 2X No	ispanic Origin In, Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)	U • S 14. Race-Black, Specify:	• A • American Indian, White, etc. Black	
1 21215-0036 led within 72 hours all ygiene per than "natural; or ner than "natural; or the than "natural Examit, the Medical Examit Completed by F	(Specify only higher Elementary/Secondary (0-12)	college (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of ()	working		us Jobs	
aryland should be file nd Mental Hy marked othe amatic event,	Calvin Willi	ams			Emma 1				
Saltimore, Maryland be file be mult. Pages 1 and 2 should be file bepartment of Health and Mental Hymportant: If item 27 is marked oth my injury or other traumatic event bice. To Be (19a. Informant's Name/Relations Emma Gardner 20a. Method of Disposition 1 Burial 2 □ Cremation 4 Donation 5 □ Other (S	-Mother 201 3 □Removal from State pecify)	4310 D. Place of Dispo cemetery, cre Voodlav	Ridgew ostion (Name of matory or other place on Cemet	ood A		imore, 20c. Location - Ci	Md 21215	d
Balloning Department of the partment Sign ture of Funeral Service 23a. Par Lenter the disease, or shoot, or heart failure. List Immediaty Cause (Final disease) condition	complications that caused the di	eath. Do not en	ter the mode of dyin	ash Ar g, such as car	ve, Balt:	rest,	Approximate Interval Between	n h	
are be executed are be executed in burial-transit in burial-transit incal Examiner	Sequentially list conditions, If any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons Due to (or as a cons c. Due to (or as a cons d.	sequence of):						
, P.O. Box 6876 that the death certificate be ed by the attending physici detached for use as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of Month		
cords, P w requires that s been signed b s should be deta	Fait II. Other significant condita	ons contributing to death but not	resulting in the u	inderlying cause give	en in Part I.		. ,	ute to the cause of death	
I Record The law requir						24a. Was a autop perfor	sy prio med? dea	re autopsy findings availar to completion of cause th? Yes 2 No	able of
Vivision of Vitation of Attending Physician. Ider death. Intercor: After this certification: Age tuneral director. In by the funeral director.	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Homicide	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year 4/12/U 5	t home, farm, st	f 28c. Injury Work 1 U	at	Subject	ence 6 Other ow injury occurred	or Chiral Pouto Mumbos	
To the Hospital within 24 hours a within 24 hours a To the Funeral I completely filled Medical Ce	29a. Certifier (Check only one) 29b. Signature and title of certifier	g Physician: To the best of my! Examiner: On the basis of exam and manner stated.	knowledge, deat	h occurred at the tim	oinion, death o	lace, and due to the occurred at the time, o	ause(s) and mann	d due to the cause(s)	
F 3 F 8	> Zalvis	ulos AC who completed cause of death (I	tem 23a) (Type,	OC	CME		APRIL 12,		
State Registrar	7 MILL (Month, Day, Year,	1 5 2005 Alexanders Signatures Signatures	gnature		enn St	reet Balt	imore, M	aryland 212	01

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jan HOLL 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) OWSON saltimore xton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 212-07 79, Yrs. -210-15 Marylano Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE OWSON 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21286 12. Was Decedent Ever in U,S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) achinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) seorge 19a. Informant's N e/Relationship (Type, Print) 21286 orave 20b. Place of Disposition (Name of cemetery, crematory or other plece) 000501 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date BALTIMORE ML 4 Donation 5 ☐ Other (Specify) la 22. Name and Address of Fatility 21. Signature of Funeral Service Licensee D 21234. 23a. Part1. Enter the disease or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one luse on each line. 8800 HARFORD PL Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEM ENTIA Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown IADERES MELLITIS I 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Physician/Medical Examiner

or Attending Physician: The law requires that the death certificate be executed

this certificete

To the Hospital or Attending Physi within 24 hours efter death.

To the Funerel Director: After this a completely filled in by the funeral dir

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

Be Completed by

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or the any illury or other traumetic event.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

26. Place of Death (C	Place of Death (Check only one) Nursing Home 5 ☐ Residence 6 ☐ Other (Specify,		
Nursing Home	5 ☐ Residence	6 □Other (Specify

25. Was case referred to medical				26. Place of De
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	3□ DOA	Other: Nursing I

27. Manner of Death 5 ☐ Pending investigation 1-Natural 2 Accident

Date of Injury (Month, Day Year) 6 Could not be determined

28b. Time of

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

💶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person w

CHURCH LA HUDES MD 21082 5905 En unti

State Registrar

Medical Certification: To Be Completed by

31. Date filed (Month, Day, Year) APR 1 5 2005



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year 08-30 AM Nelson Lee Kyle, Jr. 11 2005 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours MM 2 F Yrs. Sept. 23, 1923 216-16-2629 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 XNo Maryland Harford **Fallston** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 909 Waters Avenue 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? ↑♥ Yes 2 □ No if Yes, Give Year or Dates: ₩₩II 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: 3√2 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturer 11 Steelworker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mattie Murile Nelson Lee Kyle, Sr. (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald N. Kyle / Son 107 Maxwell Avenue, Anderson, SC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State penation Other (Specify) Union Chapel UMC 4-15-05 Joppa, Maryland dure of Maneral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 and of 23 rt. 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final phicemia disease or condition resulting in death) Due if (or as a consequence of): aspiration Lower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown physenus 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2 No 25. Was cast referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1
Inpatient 2 □ EP/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

29c. License number

D0056607

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21014

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or than "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at

and Mental Hygiene, Is marked other than

permit. Pages 1 and 2 a Department of Health ar Important: If item 27 Is any injury or other trau once.

1 and 2 should be lealth and Mental

Director

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Completed

use as the burial-transit his Certification:

of Vital Records,

Physician/Medical Completed

e Hospitel or Attsnding Pl 24 hours after death. 9 Funerel Director: After th

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH

29a. Certifier

1 Natural

2 Accident

3 Suicide

4 | Homicide

31. Date filod (Month, Day, Year) Registrar



5 Pending investigation

6 Could not be

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State	State of Ma	aryland		rtment of H				. 0	0.05	10001
			Registrar 1. Decedent's Name (First, Middle,	l ast)		Cert	ilicale of L	Jean		2. Date of Dea	leg. No.	UUD.	3. Time of Death
	Physicia		501,00	Ku	100					Month	Day 0 9	Year LOUS	8
4	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of	of Death	HP!		nty of Death	0070
	LAGITILI		Howard Loun	to Genera	1 /40	501 FEL	COLV	mb:	4		1+	OWA	18
	Funeral		5. Social Security Number 6		e (In yrs. la	st birthday)	tf Under 1 Year Months Days	If Under	24 Hrs. g	Date of Birth	Year)	9. Birthp	place (State or Foreign
	Director		215-55-2032	15XM 2□ F	23	Yrs.	Working Days	riodis		ov. 21			
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	ation					1	0d. Inside City Limits
	Maryl fehc	ō	MD Howard	Ē	El	licott	City						1 ☐ Yes 2 XNo
partition of the proof of the control of the control of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. importent: if item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Marical Examinar must be notified at money.		rec	10e. Street and Number		1		10f. Zip Code				10g. Citizen	of What Cour	ntry?
		Funeral Director	6242 Woodcrest	Orive			21043				Kor	ea	
	ems :	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S		as Decedent of Hi Yes, specify Cuba	spanic Orig	gin? (Speci	fy Yes or No-		Race - Americ Black, White,	
2	or it		Never Married 2☐ Marrie	d 1 □ Yes 2 □ X	No		☐Yes 257No	Specify:	.,	, oto.,			ian
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9	Menta Menta arked artic e	70 E	Hyuk Jun Kwon					Young	g Soo	k Lee			
g	2 sho and is ma		19a. Informant's Name/Relationshi		İ		Address (Street a				-		
2 1)	l and lealth im 27 her tr		Hyuk Jun Kwon -	rather	20h Blo		Woodcrest	t Dri					21043
5	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		cer	metery, crema	ition (Name of atory or other plac	e)	Dai	ie l	20c. Locatio	on - City or To	own, State
	it. Pa rtmer rtent njury		' 4 □Donation 5 □ Other (Special Service Li		Cres	st Law	n Mem. Gi	rdns.	4/1	2/2005	Syke	sville	, MD
0	permit. Departn importe any inju		Man	5611366		Gar	y L. Kau O Washin	Eman]	Funer	al Home	e @ Mea	dowrid	lge MP, Inc. .075
	X.		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused	d the death.			-				دے صا	Approximate Interval Between
» Phy	Physician		Immediate Cause (Final disease or condition	•		000	2 MOA	, A					Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a conseque	ence of):	, - 10 (O / I	(/ (
	Examiner		Sequentially list conditions.	b. Hund	per's	59	ndron	ne	,				
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of): /							
•	and al-tran	xan	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):							
oo'	ysicien: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the buriat-transit	dicai E		d									
000	ifficate g phy as the	edic											
X O	th cert endin r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy					Date of delive	•
	e dea he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (specify)					Month	Day Year
	d by t		9 ☐ Unknown Part II. Other significent condition	e contribution to doub b	out not recul	ting in the use	darking agus aire	n in Dart I		230 Did to	bassa usa s	natábuta ta th	ne cause of death?
'n	signe signe	l by	raitii. Other significent condition	a contributing to death b	ut not resum	ung in me uni	derrying cause give	en in Part I.	•	1 □ Y			ably 4 Unknown
ecords,	v requ	ete							<u>_</u>	24a. Was a	/-		
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N I G	an: T	e C	25. Was case referred to medical					26 Place	of Dogth /	1 ☐ Yes Check only or	2 No	1 🗆 Yes	2□No
	Physiclen: r this certificated director,	o'B	examiner? 1 ☐ Yes 2 ∰No	Hospital: 1 ☐ Inpatie	ent 2 E	R/Outpatient	3 DOA Othe	200	-	e 5 ☐ Resid		Other (Specif	v)
5	는 두급	on; T	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 2	28b. Time of Injury	28c. Injun	at at		d. Describe h			
2	endir sath. or: Al	atic	2 Accident investiga					Yes 2 □ I	No				
DIVISION	or Att fter d Sirect in by	ertificati	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin	ed 286. Place of Inj	iury - At hom ic. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28	f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	I Route Number,
	pitei ours a erei E	O	29a. Certifier	Physicien: To the best	of my know	lodgo doath	occurred at the time	and data an	d =l=== ==	al alvo to the c			
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medicel E	keminer: On the basis o and manner st	if examinatio ated.	on and/or inve	stigation, in my of	pinion, dea	th occurred	l at the time, o	late and plac	e, and due to	tated. the cause(s)
	ro the within roughly comply	Me	29b. Signature and title of certifier				29c. License	number		- 2	29d. Date sig	ned (Month,	Day, Year)
ı			Harry 1	in En	ste	dent	04	1137	ت ر		AOF	09	2005
	3		30. Name and address of person w	ho completed cause of c	death (Item 2	23a) (Type, P	rint)				-17		
				1115 m	57	55 6	W4	Colu.	nbiA	, md	210	47	
97	Sta Registr		31. Date filed (Month, Day, Year) APR 1	32. Registr	rar's Signatu	de de	29c. License 0 4 Irint) 44-4		•				
b	riegisti	e.	HFR I	, 2000	18000 3	- 5	8						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 3. Time of Death O 2. Date of Death **Physician** 2129 WILLIAM LEWIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANDALLSTOWN BALTIMOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Day, Min. (Month, Day, 7. Age (In yrs. last birthday)
Yrs. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limit item 27 is marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be redified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director 10g. Citizen of What Country? 21133 12. Was Decedent Ever in U.S. Armed Forces? 1 ID Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Dever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) nd Mental Hygiene. marked other then 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked ot ျှ LPII)IS Illan Jones 19b. Mailing Address (Street and Number or R r 19a. Informant's Name/Relationship (Type, Manor 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition permit. Pages
Department of I
Importent: If ite
any injury or ot 1 Burial 2 □ Cremation 3 Removal from State 4-15-05 4 ☐ Donation 5 ☐ Other (Specify) laughn C. Greene Fundral Souc. 21. Signature of Funeral Service Kandallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR FIBRILLATION Physician /Medical Due to (or as a consequence of) Examiner COMPI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Examiner that the death certificate be executed burial-transit BARI LONGEST Due to (or as a consequence of): physician the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy 2)X No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Dippatient မ 2 (No 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: after death. Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ∠ □ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number certifie 29b. Signature and title of D53910

Registrar DHMH 17 Rev 1/2001

State

RANDALLSTOWN.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

A. Registrar's Signature

MAHESHWARI

1 5 2005

31. Date filed (Month, Day, Year)

APRIL 10. 2005

			Tiedde	State of Maryla		artment of F		Mental Hyg	iene	10000
		1	For State Registrar		Ce	rtificate of	Death		eg. No. 4 UUJ	15339
1	Physicia	100	1. Decedent's Name (First, Middle, Las	st)				2. Date of Deal Month	Day Year	3. Time of Death
	/Medic	al	Dennis Allen Leag			4h City Town o	r Location of Deatl	March 3	4c. County of Deat	8:40 p M
	Examin	C1	4a. Facility Name (If not institution, given 4316 Spencer Stree			Haletho			Baltimore	
6.	Funeral		5. Social Security Number 6. S	ex 7. Age (In yr	s. last birthday			8. Date of Birth	9. Birt	hplace (State or Foreign untry)
	Director		214-44-5845	⊠м 2□F 58	Yrs.	World S Day S	Tiodio Iviiii		, 1947PA	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or L	ocation				10d. Inside City Limits
	Maryli f sho	Į.	MD Baltimor		Haletho	2500				1 □ Yes 🍱 No
	r 28e	Director	10e. Street and Number	е	naietm	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	th wit		4316 Spencer St.			21227			USA	
	er dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by F	1 ☐ Never Married 2 ← Married 3 ☐ Widowed 4 ☐ Divorced	1√2 Yes 2 □ No 1 If Yes, Give Year or Dates: 19	967 68	1 ☐ Yes 2 ☐ No	Specify: wh:	ite	Specify:	white
9	within 72 hours after death with the Maryland one. Than "natural", or Itams 23c or 28e-f show he Medical Ezani her must be notified at		15. Decedent's E (Specify only highest gra		16a. Dece	edent's Usual Occup e kind of work done	pation during most of wo	rkina	16b. Kind of Business	Industry
21	ithin 7 ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)			
121	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)	Manag	ger	18. Mother's Nar	me (First, Middle,	Warehouse Maiden Sumame)	
and	ould be f Mental I karked of	To Be	Clifton Garfield				Doroth	ov Elizab	eth Deardo	rff
Maryland 21215-0036	should and Men a marke umetic	-	19a. Informant's Name/Relationship (19b. Mail	ing Address (Street			r, City or Town, State, J	
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygener if the with and Mental Hygener in the Marylan 27 is marked other than "natural", or Itams 23 to 7 28e-f show than traumetic avant, the Marylal Exam nor must be notified at		Patricia Leager-				St. Hale		Maryland 21	
Baltimore,	Pages 1: nent of He int: If itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery, cre	osition (Name of omatory or other pla	ce)	Date	20c. Location - City or	Town, State
ţim	t. Pag rtment rtant:		4 ☐ Donation 5 ☐ Other (Special Service Lice		Löudön	Cremato: Park 22. Name and Addre	ess of Facility Lo	oudon Par	Baltimore k Funeral	City
Bal	permit. Pages Department of I Important: If iti any injury or o		21. Signature of Fulleral Service Lice	11300					, Maryland	
			23a. Part. Enter the disease, or com- shock, or heart failure. List only	pplications that caused the de						Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	one dades on each mis-	14	VG CF	INCER	2		Onset and Death 2 YEARS
+	/Medical		resulting in death)	Due to (or as a cons	sequence of):					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
g.	Examiner	Ļ	Sequentially list conditions,	b. Due to (or as a cons	equence of:					
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due 10 (01 as a 001)	oquorios sij.					
~	execu n and ial-tra	Examine	resulting in death) Last	C. Due to (or as a cons	sequence of):					
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical		d						
, 68	entifica ing ph e as ti	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	ananov.				23d. Date of de	li tont
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □ F	etal death 3	☐ Ectopic pregnand	У		Month	Day Year
O.	that the de ned by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown			div			
Δ.	es that igned b be deta	by Pt	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause gr	ven in Part I.	N 4	obacco use contribute t	
Records,	v require							100	/es 2∐No 3∐P	robably 4 Unknown
ecc	has be	Completed						24a. Was autop perfo	sy prior to	utopsy findings available completion of cause of
		Con						1 ☐ Yes	2 No 1 Yes	s 2 No
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	□ EB/Outpati	ent 3 DOA	26. Place of De her: 4 ☐ Nursing	eath Check onl o	ne dence 6 ⊡Other (Spe	ecify)
of	Phys er this eral di	-	1 ☐ Yes 23 No 27. Manner of Death	28a. Date of Injury (Month, Day Year		of 28c. Inju			now injury occurred	,
ion	Attending For death. Botor: After by the funer	ation	1 Natural 5 Pending 2 Accident investigate	on	/ Injury		Yes 2□No			
Division	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		t home, farm, secity)	street, factory, office		28f. Location (S City or Tox	Street and Number or R vn. State)	lural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	i Ce	29a, Certifier 1 Certifying F	Physician: To the best of my	knowledge, de	ath occurred at the t	ime, date and place	e, and due to the	cause(s) and manner a	s stated.
	e Hos 24 hc s Fun letely	Medical	(Check only 2 Medical Exa	aminer: On the basis of exam and manner stated.	nination and/or	investigation, in my	opinion, death occ	curred at the time,	date and place, and du	e to the cause(s)
e.	To the within 2 To the comple	Me	29b. Signature and litle of certifier	0.1	_		ise number	1	29d. Date signed (Mon	
			· /w	COLL M	1)	DI	6354		HPRIL 4,	2005
	1241		30. Name and address of person who E. W. COLE	STAGNES	900	e, Print) CATON A	WE B		4D 212	
	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 15	32. gistrar's S	ignature	perso				

		1 - State of Maryland / Department Certificate			iene 0 0 5	12997
Physic /Medi		Decedent's Name (First, Middle, Last) DOROTHEA H. LONG		2. Date of Death Month APRIL	Day 2005	3. Time of Death 8:00 P.M
Exami		OAK CREST CARE CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	own, or Location of Death PARKVILLE	8. Date of Birth (Month, Day,	4c. County of Deat	h IMORE hplace (State or Foreign untry)
Director		Usual Residence of Decedent	Days Hours Min.	03-27-1	916 M	ARYLAND
Marylar a-f show	ctor	MD. BALTIMORE 10c. City, Town or Location	ARKVILLE			10d. Inside City Limits 1 ☐ Yes 2 💢 🖔 o
h with the 23a or 28 at be no	al Director	10e. Street and Number 10f. Zip C 8800 WALTHER BOULEVARD	21234	10	Og. Citizen of What Co	•
nours after deal	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Sive Year or Dates: 13. Was Decedent Ever in U.S. If Yes, Sive Year or Dates:	nt of Hispanic Origin? (Spec y Cuban, Mexican, Puerto R XXIo Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:	
iolo; inicityicitia ZIZIS-0030 ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If Item 27 is merked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examples must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS 16a. Decedent's Usual (Give kind of work life. DO NOT use SECRE)	done during most of working retired)	g 1	6b. Kind of Business/l	,
al yialiu should be file ind Mental Hy s marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) WILLIAM J. HOLLENDER	18. Mother's Name HORTENS		(UNKNOWN)	
and 2 sho ealth and I m 27 is me			Street and Number or Rural SYLVANIA AVEN			
DCALLINGTE, INITION PROPERTY AND 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition 1 □ Burial XXCremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or other HTLLTOP SERVICE	er place)		Oc. Location - City or TOWSON, MARY	Town, State YLAND, 21204
permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Licensee 22. Name and A	Address of Facility WSON FUNERAL	2.00	1050 V	מאח אמר
Physician /Medical Examiner popularian and provided prov	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	of dying, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
death certificate be death certificate he attending physical for use as the	Physician/Medicai	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[\text{Ves} \] 2 \[\text{No} \] 9 \[\text{Unknown} \] Unknown			23d. Date of delin Month	very Day Year
quires that the signed by tail be detach	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.		acco use contribute to	^/
ysician: The law requires to certificate has been significate has been significate, page 2 should	Completed			24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
anding Physicial ath. Sath. T. After this certishe funeral directors.	atlon; To Be	2 ☐ Accident investigation M		e 5 🗆 Residen) nce 6 □Other (<i>Spec</i> vinjury occurred	ify)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	I Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify) 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the street of the s		City or Town,		
thin 24 ho the Fun the Fun mpletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred	at the time, dat	e and place, and due	to the cause(s)
F 3 F 8) () ()	J311		d. Date signed (Month)	20 L
5		30. Name and a res of p rson who completed cause of death (Item 23a) (Type, Print) Tith Longram Stoo walth 131.	Park-16 r	W 2128	37	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

DOLO THEA

•	Phy /N Exa	ysi lec am
P.O. Box 68/60,	hat the death certificate be executed	d by the attending physician and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 5 Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LEVIN : 50 PM MOLLIE APRIL 2005 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner of Balh more Hospital Ralhmore N/A 8. Date of Birth (Month, Day, Year) JAN. 27, 1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2₩F MD 216-18-7101 81 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits other treumatic event, it e Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director OWINGS MILLS BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA "neturel", or Items 23e 3 SHADED GLEN COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married WHITE 1 ☐ Yes 2 📉 No Specify ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h HIGGER ANNIE WEINER SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum once. 3 SHADED GLEN COURT - OWINGS MILLS, MD 21117 EDWARD LEVIN / HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) SHAAREI TFILOH CEMETERY 4/14/05 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cian peach w .OY disease or condition resulting in death) lical Due to (or as a consequence of) iner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No certificate has been signed by the atterector, page 2 should be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1/2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Hospitel or Attending Pl
 24 hours after death.
 Funerel Director: After the 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 123456 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Baltman , MI ARODO KHAWAJA-32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 5 2005 Registrar

			1- For State of Maryland / Dep	ertificate of Death	Mental Hygier	Z11115 12999
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		MICHAEL FRANK MARINO		April 1	PŽ, 2ŎŨ5 9:30PM
	Examin	er	4a. Fecility Name (If not institution, give street and number)			
_		6	4107 Southern Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Baltimore Hunder 1 Year Hunder 24 Hrs	8. Date of Birth	N / A 9. Birthplace (State or Foreign
	Funeral Director		215-48-7362 XX 2 55 Yrs.	Months Days Hours Min		1950 Mary Land
	ס		Usuel Residence of Decedent		- Canada y Og	
	arylar ehow	_	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits
	he M	ecto	Maryland N/A Baltimo	↑e 10f. Zip Code	100	1
	with with	Dir	4107 Southern Avenue	21206	Tog. v	USA
	ms 23	nera	11 Marital Status 12 Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
ထ္	or ite	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 🕷 o	1 ☐ Yes 2XXXNo Specify:	to Hican, etc.)	Black, White, etc. Specify: White
8	within 72 hours after death with the Maryland one. than "netural", or items 23s or 28s-f show the Medical Examination of the Medi	d by	3 ☐ Widowed 4X X Divorced Year or Dates:			
21215-0036	n 72 n	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking 16b.	Kind of Business/Industry
77	withi	ошо	Flomentary/Secondary (0-12) College (1-4or 5+)	ectional Officer	St	ate of Maryland
פ	e filed al Hygid other vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maid	en Sumame)
Maryland	should be and Mental marked c	To	Frank Robert Marino		es Edna Mic	
Mar				ling Address <i>(Street and Number or R</i> Foster Knoll Driv		
ē,	permit. Pages 1 and 2 Department of Health a important: If item 27 it eny injury or other tra once.		20a. Method of Disposition 20b. Place of Disp			Location - City or Town, State
Baltimore,	Pages nent of int: If it iry or o		M□Donation 5 □Other (Specify) GreenMoul	nt Crematory 4/		ltimore, Maryland
ati	permit. Departn Imports eny inju		1.4.	22. Name and Address of Facility M1		
_	70 F 9 9		I sennes Stephen Kenakes			ore, Maryland 21212
	Dhusisian		23a. Part1. Enter the disease, or complications that eaused the death. Do not element, or heart failure. List only one cause on leach line.	nter the mode of dying, such as cardia	dr respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical	lner	disease or condition resulting in death) Due to (or as a consequence of):	C Vasavan !	Uslask	
	Examiner		Sequentially list conditions, b.			1 years
	Sit ad		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			1/
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9	rtificat ng phy as th	e e	V SEEDAN E			
Вох	ath cel Itendir or use	an/h		□Ectopic pregnancy		23d. Date of delivery Month Day Year
0	that the death certific ed by the attending p detached for use as	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5	Other (specify)		World Day 1 Gai
<u>a</u>	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Vital Records,	w requires been sign should be	ed b	Chroniz Smolle		1 Yes	2 No 3 Probably 4 Unknown
eco	e law requ has been je 2 shoul	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	The ate h	Com			performed 1 Yes 2	death?
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	Othor	ath (Check only one)	
ō	Phys r this ral dir	. To	1 Inpatient 2 EH/Outpatie		28d. Describe how in	6 ☐Other (Specify)
lon	th.: After struer	atlor	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,
Division of	f or Attendater deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		202 Cartifier 1 Cartifying Physicians To the heat of multi-	th paragraph that in a data and it		(1)
	To the Hospital within 24 hours To the Funeral completely filled	Medica	29a. Certifier (Check only one) Check only one) (Check only one) (Check only one)	urr occurred at the time, date and place nvestigation, in my opinion, death occi	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month, Day, Year)
7	de		me	D 0145	14	4/13/05
1	0 '		30. Name and address Person who completed cause of death (Item 23a) (Type	, Print)	E1 201	7101206
	Sta	te	31. Date filed (Month, Day, Year) 32. Regispar's Signature	1 de	a boot.	1140 11111100
	Registr		APR 1 5 2005 ▶	Boule		

State of Maryland / Department of Health and Mental Hygiené 🕕 🗍 💍 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9, 2005 Thomas Francis Meagher, Jr. April 12:32 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. Director 84 12-9-1920 014-14-0764 Connecticut Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be mailised at 1 ☐ Yes 2 No Directo Maryland Lothian Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1122 Pemberton Lane 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 1944–80 14. Race · American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. s 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. Item 27 is marked other than "natural", or Ite 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Attorney at Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Francis Meagher Mabel Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen T. Meagher/ Son 1122 Pemberton Lane, Lothian, Maryland 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages the Department of Holl Important: If Ite any injury or ottone. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. 6-22-05 Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home Y Why 2973 Solomons Island Rd. Edgewater, MD 21037 MILL Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner eroscle Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 202 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 Inpatient After the funeral 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oleto 31. Date filed (Month, Day, Year) APR 1 5 2005 3. Registrar's Signature State Registrar